Healthcare Reform from Hospitals’ Viewpoint

Pandemic Preparedness

Health Care Labor Report: Labor-Management Alignment
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Arkansas Hospitals

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The Challenges of Change

In the hospital field, change is swirling around us. National healthcare reform, the implementation of RACs and MICs, and formation of Arkansas’ new trauma care network top our list right now. And joining them is the projection of an unprecedented flu season with pandemic H1N1 flu still claiming lives worldwide, and the traditional flu season soon to spike right here in Arkansas.

As hospitals – administrators, medical staff, employees, trustees and auxiliaries – we must all be seriously preparing for this challenging flu season. With both seasonal flu and the novel H1N1 flu threatening, this fall and winter are likely to bring the toughest flu event in more than a generation.

It’s something we’re facing together, with hospitals around the nation working hand in hand with their local health units, state Departments of Health, and the federal Centers for Disease Control and Prevention (CDC). It’s healthcare working with government to face this flu giant head-on, and keep our population as informed and healthy as possible. I’d say most people accept this as a good thing.

Yet I am constantly amazed at the number of people who say they don’t want government involved in their healthcare. We just celebrated the 44th anniversary of Medicare, one of the most positive and successful government healthcare programs of all time, according to recent poll results. How have people somehow lost the idea that government and their individual healthcare are already tied to one another in countless ways?

And why are people afraid of universal health coverage? Some cite intrusion and rationing as the basis of their fear. Yet, when was the last time private insurance demanded that same approval? About 10 minutes ago!

We welcome civil healthcare reform discussions occurring in Washington and across our nation. Healthcare reform, no matter what form it takes, is a necessity. At this writing, it seems the public option may be off the table, but proper insurance reform alone can do the job. We need to work together to cover those who are uninsured and/or have lost coverage or been dropped by their insurance companies, for whatever reason. It will mean change, but it should mean universal coverage, and at the end of the day, our government will have generated whatever changes occur.

Without those changes, the number of uninsured will continue to rise. More and more businesses will become unable to afford insurance premiums and will drop their employees’ coverage. More hospital emergency departments will be choked with those who seek their primary medical care in places designed to deal with true emergencies – and hospitals’ ability to keep their doors open will continue to be in question as more care is given, but less is paid for.

Perhaps I seem to be rambling a bit, but my point is that change is always with us. Today, healthcare change is at a peak. We must continue to work together to seek positive reform, strategize together to meet all challenges, and draw together aggressively to be ready for a rough flu season. Change is never easy, but it’s something we must deal with and embrace as we move forward – together.

Phil E. Matthews
President and CEO
Arkansas Hospital Association
Arthur Benson has been named CEO of Pike County Hospital in Murfreesboro. He succeeds longtime administrator Rosemary Fritts. Benson has over 20 years of healthcare consulting experience and is a partner of Southwest Healthcare LLC, who will manage the hospital.

Cris Bolin has been appointed interim administrator at Delta Memorial Hospital in Dumas, where she had previously served as assistant administrator/CFO. Ms. Bolin received her undergraduate degree in accounting from the University of Washington and will soon complete her MBA in healthcare administration with Harding University. She succeeds Craig Ortego.

John Heard, CEO of McGehee Desha County Hospital, has been named to the Arkansas Rural Practice Student Loan and Scholarship Board, representing the Arkansas Hospital Association. He succeeds Terry Amstutz, former CEO of Magnolia Hospital.

Timothy E. Hill has resigned as president and CEO of North Arkansas Regional Medical Center in Harrison, effective October 28. He has accepted the position of president and CEO of the Arkansas Heart Hospital in Little Rock and will begin that position on November 1. Hill is a member of the Arkansas Hospital Association Board of Directors, representing the Arkansas Hospital Association. He succeeds Terry Amstutz, former CEO of Magnolia Hospital.

Walter Johnson, administrator of Jefferson Regional Medical Center in Pine Bluff, has been named president and CEO of the organization effective October 1, 2009. Robert P. “Bob” Atkinson will become president and CEO emeritus and serve in that capacity until July 1, 2010. After that date, he will remain with JRMC as a consultant for another year.

Johnson joined JRMC in September 1994, after serving in various leadership positions with Humana and HMA. “With over 20 years of hospital administration experience, the Board of Directors felt confident that Walter has the education, training, experience and skills needed to lead JRMC into the future,” said Jerrel Boast, chairman of the JRMC Board of Directors.

Atkinson has been president of JRMC since 1992, during which time he also served as chairman of and Southeast District delegate on the Arkansas Hospital Association’s Board of Directors. He currently serves on the AHA Board as past-chairman and alternate delegate to the American Hospital Association’s Regional Policy Board 7. In 2008, Atkinson was recipient of the A. Allen Weintraub Memorial Award, the highest honor the AHA can bestow upon a hospital chief executive.

Tripp Smith has been named chief operating officer at Northwest Medical Center – Bentonville. Prior to accepting his new position, Smith served in administrative roles with hospitals in Louisiana, Tennessee and Alabama.

The Arkansas Hospital Association has added two new staff members. Anna Sroczynski of Benton has been named administrative assistant in the education department, and Kathy Wewers of Little Rock is the new receptionist.
There continues to be a lot of activity on the health reform front, but perhaps the biggest news of the year for hospitals came during a July 8 press conference at the White House.

Vice President Joseph Biden, subbing for the president who was away tending to foreign policy matters, teamed with representatives from the American Hospital Association (AHA), Catholic Hospital Association (CHA) and Federation of American Hospitals (FAH) to announce an agreement among the Obama Administration, the three hospital groups and Senate Finance Committee (SFC) Chairman Max Baucus about a policy framework for funding a sizeable portion of the nation’s top domestic policy agenda item.

Under the agreement, hospitals would contribute up to $155 billion over ten years, but no more, to offset the cost of expanding health coverage to up to 95 percent of the nation’s uninsured population. That’s the amount included in the Senate Finance Committee’s initial bill.

Coverage expansion is the key to meaningful health reform, but it’s also proving to be the most contentious piece of the puzzle due to the ridiculous cost. The agreed-on $155 billion reduction may have left many a hospital leader dizzy and gasping for breath at first blush, but eventually it has become clear that this isn’t such a bad deal.

Assuming it is incorporated into a final health reform package, the agreement would limit hospitals’ exposure to what could have been significantly greater Medicare reductions. The president, whose weighty hand is pushing reform before the year’s end, originally asked for hospital cuts of between $224 billion and $254 billion. Need we say more?

It also adds street cred, pairing hospitals’ acknowledgement of a responsibility for a significant contribution toward reform, with a steadfast position that they shouldn’t and can’t cover the lion’s share of the cost.

The majority of cuts would come from decreases in the Medicare inpatient and outpatient hospital market-basket updates and reductions in both Medicare and Medicaid Disproportionate Share Hospital (DSH) payments, both spread across a decade.

But, there’s a quid-pro-quo. Beyond the societal benefit of near universal coverage, hospitals should reasonably expect long term revenue increases, as practically all patients treated will have a source of payment. The expansion of coverage could produce approximately $171 billion in hospital revenues nationwide over the ten year period, according to AHA’s conservative estimates. Those coverage revenues could grow to as much as $236 billion.

Getting to the $155 billion starts with reducing Medicare market-basket updates for inpatient, outpatient, inpatient rehabilitation facilities and long-term care hospital payments. That generates a $103 billion savings over ten years. The reductions would average market-basket minus 1 percent per year.

Another $50 billion is associated with Medicare and Medicaid DSH Payments, which would be protected at current levels until 2015, when the payments for each program would be reduced by $5 billion a year through 2019.

Both the market-basket and the DSH cuts would be scaled back proportionately if coverage of the uninsured doesn’t reach certain thresholds each year.

Changes in policies governing preventable readmissions would account for the remaining $2 billion.

The agreement also includes positives related to Indirect Medical Education, community benefit reporting, value-based purchasing and bundling of payments. A public option health plan that would reimburse hospitals based on negotiated rates rather than rates determined by the Secretary of Health and Human Services or pegged to Medicare rates is still under consideration.

Understand that the health reform legislative process is far from over. Ultimately, the House and Senate will need to reconcile the differences between their respective approved bills.

Job one for hospitals is to ensure that provisions of the agreement negotiate the long and winding road and make it into a final bill that will reach President Obama’s desk.

Admittedly, an agreement to cut $155 billion from hospitals already reeling from diminished revenue streams may not be as good as it gets, especially when the hope for financial improvement is pinned to mathematical theories and predictions.

But, is it as good as we might expect, given the current environment? Pick up a Magic 8-Ball and pose that question. Chances are the answer would be “signs point to yes.”
Congressional leaders and the White House have assigned a top priority to healthcare reform in an effort to push it through this year. To show support, five healthcare organizations representing six different sectors of the healthcare industry, including the American Hospital Association (AHA), have committed to help achieve the Administration’s goal of decreasing the annual healthcare spending growth rate by 1.5 percentage points – saving $2 trillion or more.

For its part, the AHA suggested hospital initiatives for “bending the cost curve” which address immediate and longer-term cost savings. The ideas for immediate savings – developed after consulting broadly with the AHA membership and allied associations – cover eight specific areas:

- Reduce surgical infections and complications
- Reduce central line-associated bloodstream infections (CLABSI)
- Reduce Methicillin-resistant Staphylococcus aureus (MRSA)
- Reduce clostridium difficile infections (c diff)
- Reduce ventilator-associated pneumonia (VAP)
- Reduce catheter-associated urinary tract infections;
- Reduce adverse drug events from high-hazard medications (e.g., anticoagulants, narcotics, opiates, insulin, sedatives)
- Reduce pressure ulcers.
All focus on expanding efforts that already have been tested and adopted by hospitals and health systems. AHA will launch a national campaign to build upon those efforts and will ask each hospital to choose the order in which they tackle issues on the list.

The overall goal is to accelerate the pace of improvement, while broadening and deepening the success across the field. Longer-term cost savings would come from future AHA-coordinated campaigns to help promote initiatives for improving care coordination, implementing Health Information Technology (HIT), promoting efficient resource utilization, preventing patient falls, improving perinatal care and reducing supply costs.

Arkansas’ members of Congress home for the August break held a series of town hall meetings and spoke before many local civic groups, gathering Arkansans’ ideas and feelings about healthcare reform and the discussions currently being held in Washington, D.C.

As is now well-known, some of the meetings were raucous, some more civil. But the bottom line at each was the opportunity for Arkansas’ Congressional delegation to learn first-hand what Arkansans are saying about healthcare reform.
HEALTHCARE REFORM

Healthcare Premiums Rose 5.8 Times Faster than Earnings in Arkansas from 2000 through 2009:
Arkansas-Specific Report Finds that Premiums Rose by 87.7 Percent, while Earnings Rose by Only 15.2 Percent

According to a new report by Families USA (a nonprofit, non-partisan national consumer healthcare organization), family healthcare premiums rose an estimated 5.8 times faster than earnings for Arkansas’ workers from 2000 through 2009. In that 10-year period, family health insurance premiums rose by 87.7 percent, while median earnings rose by only 15.2 percent.

The Families USA report for Arkansas is an update of its original groundbreaking 2006 report, which was the first of its kind to document these changes on a state-specific basis. Among the new report’s key findings are:

- For family health coverage provided through the workplace in Arkansas, the average annual health insurance premium (employer and worker share of premiums combined) in the 2000-2009 period rose from $6,355 to $11,927 – an increase of $5,572, or 87.7 percent.
- Between 2000 and 2009, the median earnings of Arkansas’ workers rose from $20,328 to $23,424 – an increase of $3,096, or 15.2 percent.

As the report notes, the disproportionately high increases in insurance premiums have continued despite employees receiving “thinner coverage” – coverage that offers fewer benefits and/or that comes with higher deductibles, co-payments, and co-insurance. Other employers have cut costs by placing limits on which employees are eligible for coverage or by eliminating coverage for spouses and children of employees. As a result, Arkansas families are paying more but receiving less in health coverage.

Key findings in the report make clear how the burden of rising healthcare costs is being shared by employers and employees for both family health coverage and individual coverage. Among those findings:

- For family health coverage in Arkansas, the employer’s portion of annual premiums rose from $4,582 to $8,647 – an increase of $4,065, or 88.7 percent.
- For individual health coverage, the employer’s portion of annual premiums rose from $2,154 to $3,340 – an increase of $1,186, or 55.1 percent.
- For individual health coverage, the worker’s portion of annual premiums rose from $438 to $830 – an increase of $392, or 89.4 percent.

“For America’s businesses and families, the absence of health-care reform is unaffordable and unacceptable,” said Ron Pollack, executive director of Families USA. “It will mean that businesses have a harder time staying competitive, and more and more families have to cope with stagnant wages and the loss of affordable health coverage.”

Pollack cited four of the many causes of skyrocketing healthcare premiums: wasteful healthcare spending; an almost unregulated insurance market; a dramatic drop in competition in the insurance market; and costs shifted from the uninsured to the insured, termed a “hidden health tax.”

“All of these issues can be addressed in a comprehensive reform of our healthcare system that will allow businesses and families to afford quality health coverage,” Pollack said.

The Families USA report is based on data from the U.S. Census Bureau, the U.S. Department of Labor, and the U.S. Department of Health and Human Services.
Report Shows Steep Premium Rise

Opponents of healthcare reform who like to point out that “80% of Americans are satisfied with the quality of healthcare coverage they are receiving” may find far fewer happy campers in just a few years, if a new report by the Commonwealth Fund is correct.

The report, *Paying the Price: How Health Insurance Premiums Are Eating Up Middle Class Incomes, State Health Insurance Premium Trends And The Potential Of National Reform*, makes dread-fuelly clear the reason why healthcare reform is such an important matter to address now. It estimates that family premiums for employer-sponsored health insurance, which increased 119% between 1999 and 2008, could increase another 94% to an average $23,842 per family by 2020 if cost growth continues on its current course. That could shift many of those who enjoy employer sponsored coverage today into the ranks of the uninsured, where satisfaction with coverage is non-existent.

The report finds that national reforms that slow healthcare cost increases by 1% to 1.5% per year would yield substantial savings for families and employers. By 2020, slowing the annual rate of growth by 1% would yield more than $2,500 in reduced premiums for family coverage, and slowing growth by 1.5% would yield more than $3,700 in premium savings compared to projected trends. Find the complete report at http://www.commonwealthfund.org/Content/Publications/Data-Briefs/2009/Aug/Paying-the-Price-How-Health-Insurance-Premiums-Are-Eating-Up-Middle-Class-Incomes.aspx.

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Proposed 2010 Hospital Outpatient Rule

The Centers for Medicare & Medicaid Services (CMS) in July released its proposed rule updating payment policies and rates for hospital outpatient departments and ambulatory surgical centers (ASC) for calendar year (CY) 2010.

CMS projects that proposed payment rates under Medicare’s outpatient prospective payment system (OPPS) would result in a 1.9 percent increase in Medicare payments for providers.

Among other provisions, the proposed rule includes changes to the hospital outpatient quality data reporting program, and would establish procedures to make the data collected through the reporting program publicly available.

CMS plans to issue a final rule by November 1.

Key components of the proposed rule include:
• Market-basket Factor: Hospitals would receive a full market-basket update of 2.1 percent, except for those that are non-compliant with the reported outpatient quality measures. They get the market-basket update minus 2.0 percentage points. CMS is proposing to increase the conversion factor from $66.059 in CY 2009 to $67.439 in CY 2010. The 2.1 percent increase in the conversion factor is offset by reductions for changes in outlier payments, pass-through estimates and the expiration of the Section 508 reclassifications; therefore, overall Medicare OPPS payments are expected to increase by 1.9 percent in CY 2010.
• Outliers: The outlier fixed-dollar threshold increases from $1,800 in CY 2009 to $2,225 in CY 2010. Outlier payments would be provided when the procedure cost exceeds 1.75 times the ambulatory payment classification (APC) payment amount and the APC payment rate plus the fixed-dollar threshold.
• Hold-Harmless Transitional Payments: Existing hold-harmless transitional outpatient payments (TOPs) paid to rural hospitals and sole community hospitals with 100 or fewer beds will expire on December 31, 2009. CMS does not have the authority to extend these payments beyond CY 2009 without legislation. The U.S House of Representatives’ tri-committee health reform discussion draft legislation does include a provision to extend hold-harmless TOPs through January 1, 2012.
• Quality Measures: No changes to the current 11 outpatient quality measures that hospitals must report on for CY 2010. Hospitals that failed to report required measures in CY 2009 would receive a reduction of 2.0 percentage points to their market-basket update in CY 2010. CMS intends to publicly report OPPS measures sometime in 2010.
• Validation of Quality Reporting: There is a quality reporting validation process for CY 2011. Hospitals would be required to participate in the process to receive their full annual payment update; however, the results of the data validation would not affect payment updates.
• Composite Ambulatory Payment Classification (APC) Groups: The current 10 composite APCs for CY 2010 remain unchanged. However, CMS will evaluate the implications of creating new composite APCs for cardiac resynchronization therapy with a defibrillator or pacemaker along with other potential composite APCs for future discussion.
• APCs: The list of procedures that would be payable under OPPS would be expanded to include pulmonary and intensive cardiac rehabilitation services.
• Ambulatory Surgical Centers (ASCs): CMS is proposing a number of provisions regarding ASCs, including implementation of the third-year of a four-year phase-in to align ASC and OPPS payments, as well as expanding the list of procedures that are payable under Medicare when performed in an ASC.

A display copy of the 1,000-page rule is available at the CMS Web site: http://www.federalregister.gov/OFRUpload/OFRData/2009-15882_PI.pdf.

CMS has also posted a fact sheet on the proposed rule that may be found online at: http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3472&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=showAll=&year=&desc=&cbFolder=6.
AHA Annual Meeting a Success

Passing health reform legislation this year may not be the lock-up cinch that death and taxes are, but it probably doesn’t lag far behind either of those certainties. While it’s doubtful anyone has yet fully determined how the reforms to come will impact patients, payers and providers, most believe they will place emphasis on achieving more with less. The performance and precision needed to do so could be the difference between future successes and failures. One of the best ways for Arkansas hospitals to learn the secrets for those successes was by attending the 79th Annual Meeting and Trade Show of the Arkansas Hospital Association (AHA), held October 7-9 in Little Rock.

Taking a cue from the many voices of reform that have emerged during the health reform debates, the meeting centered on the underlying theme, Arkansas Hospitals: Many Voices, One Community, and offered numerous opportunities for hospital executives, trustees and managers of functions ranging from nursing and marketing to human resources, compliance and quality improvement to honing skills for fine-tuning teamwork to improving operational areas.

It all began with a special four-hour Leadership Workshop on Wednesday, October 7. Friday Night in the ER is a learning game that serves as a tool for hospital managers who need to work together to improve performance. Workshop leader William J. Ward Jr., MBA, director of the MHS Degree Program in Health Finance and Management, Johns Hopkins University Bloomberg School of Public Health, worked with participants as they addressed challenges of managing a hospital during a typical 24-hour period. The game replicates the dynamics seen in any system when multiple goals drive people’s behavior. That same evening, Arkansas Blue Cross Blue Shield hosted its annual welcome reception, always a valuable networking time.

The program lineup for Thursday morning, October 8 included a choice of two concurrent sessions. First was the annual ACHE/AHEF breakfast highlighted with a presentation entitled “Thoughts from My Foxhole” in which Major General David A. Rubenstein, Deputy Surgeon General-Army and immediate past chair, American College of Healthcare Executives, discussed the military’s healthcare role and the medical advances now being used in civilian medicine. Plus, Ronda Hughes, senior health science administrator, Agency for Healthcare Research and Quality, facilitated a patient safety/quality leadership workshop.

Thursday’s keynote address, “New Heights in Quality and Patient Safety: Lessons from a Blue Angel,” was presented by John Foley, Former Lead Solo, U.S. Navy Blue Angels. During his very special visual presentation, Foley demonstrated the process of taking the best you have and making it better. Want to find how to improve the performance of an elite, highly-trained group of people who routinely achieve levels of extreme precision by an additional 300 percent? Foley shared some lessons he learned as a Blue Angel for achieving the level of focus, drive, commitment and trust required to fly planes at incredible speeds, 36 inches apart … and doing it upside down.

On Friday morning, October 10, a special membership breakfast on health reform updated attendees on the issues, followed by an ACHE Category I Workshop led by Lawrence J. Voyten, RN, senior vice president, Mack/Voyten & Associates, Brecksville, Ohio, who covered methods that hospital executives can use to accelerate the decision-making process to improve performance and reduce conflict.
EMTALA Interpretive Guidelines Update

On May 29, CMS issued a transmittal to the State Operations Manual in which it updated Appendix V, the Emergency Medical Treatment and Labor Act (EMTALA) Interpretive Guidelines.

The transmittal amended the Interpretive Guidelines to include the information, clarifications and revisions that have been released over the past four years in Survey and Certification Memoranda.

The following are some of the items now incorporated into the Interpretive Guidelines:

• Several statements emphasizing that any participating Medicare hospital (regardless of whether it has a dedicated emergency department) is required to accept appropriate transfers of individuals with emergency medical conditions if the hospital has the specialized capabilities not available at the transferring hospital and has the capacity to treat those individuals;

• A detailed discussion of a Medicare hospital’s option to satisfy its on-call obligations through participation in a community call plan;

• A description of various information that must be incorporated into a facility’s call coverage policies, such as the procedure for handling the unavailability of a particular specialty or physician;

• Specific provisions addressing a hospital’s option to allow simultaneous call and/or scheduled elective surgery while on call, if the hospital has a properly drafted policy incorporating a plan to provide emergency services if a physician is unavailable;

The transmittal amended the Interpretive Guidelines to include the information, clarifications and revisions that have been released over the past four years in Survey and Certification Memoranda.

• A list of the factors that CMS will consider when determining the adequacy of a hospital’s on-call list, which includes the number of physicians on the medical staff, other demands on these physicians, the frequency with which individuals with emergency medical conditions typically require the stabilizing services of the hospital’s on-call physicians, and the provisions the hospital has made for situations in which a physician on call is not available or is unable to respond due to circumstances beyond his/her control;

• A statement that CMS will expect adequate after-hours call coverage for a particular service or procedure if the hospital regularly performs such services during regular business hours or holds itself out as a “center of excellence” for the services; and

• Descriptions of the various options for transferring an unstable individual and the requirements for each option, as well as a listing and discussion of the four requirements for an appropriate transfer.

The revised Interpretive Guidelines are available online (with revised language in red italics) at www.cms.hhs.gov/transmittals/downloads/R46SOMA.pdf.

LEGAL NOTE:
Red Flags Rule
Delayed Again -
Until November 1, 2009

The “Red Flags Rule” identity theft regulations were originally scheduled to be enforced on November 1, 2008, but the enforcement date was postponed to May 1, 2009, and then until August 1, 2009.

However, in response to a request from the U.S. House of Representatives Appropriations Committee, the Federal Trade Commission (FTC) has again delayed the enforcement date of the Rule until November 1, 2009.

The Appropriations Committee requested not only that the FTC defer enforcement of the Red Flags Rule, but that it take action to minimize the burdens of the Rule on healthcare providers and small businesses with a low risk of identity theft problems.

Accordingly, the FTC plans to increase its efforts to educate small businesses and other entities about compliance with the Red Flags Rule and provide additional resources and guidance to clarify whether businesses are covered by the Rule and what they must do to comply.

Those additional resources and guidance will be posted on the FTC’s Red Flags Rule Web site, www.ftc.gov/redflagrules.

These Legal Notes are provided solely for informational purposes and do not constitute legal advice. Readers are encouraged to consult with their own attorneys about any legal issues, including those discussed in these articles.
In April of this year, CMS announced a demonstration project that will evaluate hospital readmission rates for Medicare beneficiaries in 14 communities across the country. The demonstration stems from growing concerns over the increased Medicare costs associated with hospital readmissions.

The financing agency has stated the overarching policy driving the demonstration is to improve healthcare processes by engaging caregivers and all providers from a community-wide perspective to prevent patients from being readmitted to hospitals. CMS hopes that sustainable and replicable strategies will emerge that can be applied across the nation to create seamless transitions for patients moving from the hospital to home, skilled nursing care or home healthcare.

Each of the 14 communities will be led by its QIO who will be refining and reviewing the various delivery system strategies. Specifically, the QIOs have been tasked with partnering with the communities to: evaluate hospital and community-wide strategies, assess interventions that target specific diseases, and target specific interventions for the most frequent causes of readmission.

Monitoring the readmission demonstration will be important for providers as the project indicates a major step forward in CMS’s movement toward a quality-based payment model which aligns well with the current value-based purchasing initiatives already under way.

Policy makers set on getting control of healthcare costs will likely be watching the results of this project closely, including the Obama Administration, which has made fraud, abuse and waste in Medicare a top priority in the health reform discussions.

Hospitals will want to become familiar with policies and strategies being used in this and other demonstration projects as future reimbursement will certainly be tied to new quality indicators such as re-hospitalization rates.

Hospitals and providers should consider revisiting their current discharge coordination efforts and resource allocation in an effort to minimize re-hospitalizations.

*The AHA thanks John Render of the law firm of Hall, Render, Killian, Heath & Lyman for this Legal Note.*
Competition Management can be difficult for hospitals, particularly in today’s fast-paced, financially challenging and highly regulated environment. To that end, careSkills, a derivative of the highly popular careLearning.com Web training program, is now being offered to AHA members through AHA Services, Inc.

Please examine the flyers located here to learn more about this innovative program, then call Liz Carder, AHA Services, Inc., for help enrolling in the careSkills program. You may reach Liz at the Arkansas Hospital Association, 501-224-7878.

Medicare IPPS FY 2010 Final Rule

The Centers for Medicare & Medicaid Services (CMS) have issued a hospital inpatient and long-term care prospective payment system Final Rule for fiscal year (FY) 2010 that would increase average inpatient payments by 1.6 percent. The Final Rule includes a market-basket update of 2.1 percent for those hospitals that submit data on quality measures. Hospitals not submitting data would receive a 0.1 percent update.

While the proposed Rule initially included a cut of 1.9 percent to eliminate what CMS claims is the effect of coding or classification changes, which the agency says do not reflect real changes in case-mix, the Final Rule does not implement this cut. This represents an increase of $2.2 billion in payments to hospitals in FY 2010. CMS stated that it will wait until it analyzes data from FY 2009 before it makes a documentation and coding-related cut.


Funds for Improving Healthcare Facilities:
Grants and Loans from American Recovery and Investment Act

The U.S. Department of Agriculture’s Rural Utilities Service has announced plans to award $1.19 billion in grants and loans to build or improve healthcare facilities in low-income, rural communities.

Authorized under the American Recovery and Investment Act, the funds will be awarded through September 2010. Under the terms of the act, preference will be given to improvement projects that can be executed within 120 days.

**Home Health PPS Rule Proposed**

The Centers for Medicare and Medicaid Services (CMS) has released its proposed Home Health Prospective Payment System (HHPPS) rule for calendar year (CY) 2010, which would reduce overall HHPPS payments by 0.86 percent. All payment changes are effective January 1, 2010.

Although CMS is proposing a full market-basket update of 2.2 percent for CY 2010, the national standardized 60-day episode rate would be reduced by 2.75 percent to account for changes due to documentation and coding, and further reduced for other factors, resulting in an overall net reduction of 0.86 percent in the Medicare HHPPS payments.

Highlights include the following proposals:

- **National Standardized 60-Day Episode Rate**: An increase for the national 60-day episode rate from $2,271.92 in CY 2009 to $2,317.47 in CY 2010. This 2 percent increase includes a full market-basket update and the reduction for coding changes. In addition, there is a 2.5 percent increase to the rate for the transfer of funds from the outlier carve-out. Home health agencies that do not submit the required quality data will receive a 2.0 percentage point reduction to the national standardized 60-day episode rate.

- **Outlier Payments**: Reduce outlier pool payments as a percent of total HHPPS payments from 5 percent in CY 2009 to 2.5 percent in CY 2010, and return 2.5 percent of the outlier carve-out to the national standardized 60-day episode rate. In addition, CMS is proposing to cap outlier payments at 10 percent per agency for CY 2010.

- **Quality Measures**: No changes to the current 12 home health quality measures reported for CY 2010. However, for CY 2011, CMS is proposing to expand the measures to include the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for home healthcare. In addition, CMS is proposing that participating home health agencies conduct a dry run of the survey for at least one month in the first quarter of 2010 and submit those results to the Home Health CAHPS Data Center by June 23, 2010.

- **Low Utilization Payment Adjustment (LUPA)**: Increasing the LUPA add-on payment amount from $90.48 in CY 2009 to $94.90 in CY 2010.

- **Non-routine Medical Supplies (NRS)**: CMS is proposing to increase the NRS conversion factor from $52.39 in CY 2009 to $53.44 in CY 2010. Payments for NRS are reduced by the 2.75 percent adjustment for changes in coding and documentation.

- **Outcome and Assessment Information Set (OASIS)**: Use of a new version of the OASIS data called OASIS-C to collect data on all episodes of care beginning on or after January 1, 2010. According to CMS, this new version will have little to no impact on the quality data reporting requirements for the CY 2011 under the HHPPS.

A display copy of the proposed rule is available at [http://www.cms.hhs.gov/HomeHealthPPS/HHPPSRN/list.asp#TopOfPage](http://www.cms.hhs.gov/HomeHealthPPS/HHPPSRN/list.asp#TopOfPage), click on “Publication Date Descending,” refer to CMS-1506-P.

**Designing a “Grateful Patient” Fundraising Program**

As always, fundraising is a challenge. But in today’s economy, the challenge is even more daunting. Grateful patients and their families are a select group of individuals who make donations based on their positive personal experience with your hospital. They are a viable target audience for your hospital’s philanthropic efforts. However, fundraisers need to build a personal relationship with this audience.

On November 10, the Arkansas Hospital Association will offer a workshop designed to enable participants to mobilize this population currently being tapped by only 20 percent of our nation’s hospitals. “Designing, Implementing and Marketing a Grateful Patient Fundraising Program” will offer many tools for “Fundraising 101” and the art of marketing such a program.

Facilitators Jeanette Wagner of Communications, Inc. and Mary Ellen Kubit, director of development for Youth Home, Inc. in Little Rock, are experienced leaders in marketing and fundraising.

Program information is available at [http://www.arkhospitals.org/calendareducworkshops.htm](http://www.arkhospitals.org/calendareducworkshops.htm). This workshop includes the AHA’s “two-for-one” registration fee!
Hospital trustees today need quality education in order to perform the duties required of them by their positions. On November 6, the Arkansas Hospital Association and the Arkansas Association of Hospital Trustees will present “Essentials of Hospital Governance” at the Crowne Plaza in Little Rock. This workshop offers new and seasoned Board members an overview of healthcare governance, and the primary roles and responsibilities of hospital trustees in today’s challenging and changing healthcare environment.

Participants will learn about healthcare delivery system governance; Board fiduciary duties; the basics of healthcare finance; the Board’s role in overseeing quality and safety; Board/CEO relationships; the hospital mission, strategy and stakeholders; and governance effectiveness. Healthcare governance consultants Dr. Connie Curran and Mary Totten will lead the workshop.

Both leaders bring many years of knowledge and experience in the healthcare field. Curran has 30 years as a consultant in academic and hospital system and healthcare association leadership. She is president of Curran Associates and immediate past-chair of the board of Silver Cross Hospital in Joliet, Illinois, named a Solucient Top 100 hospital for the past five years. Totten specializes in governance, education and communications. She was co-founder of Health Governance Digest, a national newsletter for healthcare boards, and an owner and principal of the American Governance & Leadership Group, which was purchased by the American Hospital Association and is now the AHA’s Center for Healthcare Governance.

Program and registration information is available at http://www.arkhospitals.org/calendareducworkshops.htm. This is an incredible opportunity for your Board to learn from noted leaders in the field at a very low registration fee. For additional information, please contact Beth Ingram at bingram@arkhospitals.org.
Arkansas moved one step closer to having a fully operational trauma care system in late August when the state’s Trauma Advisory Council approved 69 hospitals to begin work toward meeting the requirements necessary for being designated as Level I, II, III or IV trauma centers.

Sixty-six Arkansas hospitals submitted applications of intent to be a part of the system. All were approved to take their next steps toward designation based on the level of care they can provide. Three other out-of-state, border-city hospitals were also approved to proceed, all as Level I centers. The out-of-state hospitals will be paid on the number of Arkansas trauma patients treated at their hospitals, not their total number of trauma patients.

All participating hospitals will receive grants from the Arkansas Department of Health to help offset the costs associated with meeting trauma center criteria. The initial grants are expected to be awarded in November.

Grant funds are made available through a cigarette tax enacted during the 2009 legislative session. Hospitals with Level I trauma centers are eligible for grants of $1 million. That amount decreases for lower level centers (Level II-$500,000, Level III-$125,000 and Level IV-$25,000).

Initial grants will be for half the amount, with the second half paid out when the hospitals meet state standards and undergo site visits. Hospitals seeking Level I designation have 18 months to ramp up, while all others get a year.

In addition, money is available for a trauma registry and a central call center, which is critical to the overall purpose of the trauma system to link hospitals and other emergency medical services providers with better communications and a common set of emergency care rules to ensure that patients get the specific trauma care they need as quickly as possible.

**LEVEL 1 PARTICIPANTS**

- UAMS Medical Center, Little Rock
- Regional Medical Center, Memphis
- St. John’s Hospital, Springfield, Missouri
- Arkansas Children’s Hospital, Little Rock
- Le Bonheur Children’s Medical Center, Memphis

**LEVEL 2 PARTICIPANTS**

- Jefferson Regional Medical Center, Pine Bluff
- Sparks Regional Medical Center, Fort Smith
- St. Joseph’s Mercy Health Center, Hot Springs
- Baptist Health Medical Center – Little Rock
- St. Vincent Infirmary Medical Center, Little Rock

**LEVEL 3 PARTICIPANTS**

- Conway Regional Medical Center, Conway
- White County Medical Center, Searcy
- North Metro Medical Center, Jacksonville
- North Arkansas Regional Medical Center, Harrison
- White River Medical Center, Batesville
- Saline Memorial Hospital, Benton
- Arkansas Methodist Medical Center, Paragould
- Johnson Regional Medical Center, Clarksville
- CHRISTUS St. Michael Health System, Texarkana, Texas
- Ashley County Medical Center, Crossett
- Baptist Health Medical Center – North Little Rock

**LEVEL 4 PARTICIPANTS**

- Baptist Health Medical Center – Heber Springs
- Baxter Regional Medical Center, Mountain Home
- Mercy Medical Center, Rogers
- St. Bernard’s Medical Center, Jonesboro
- St. Edward Mercy Medical Center, Fort Smith
- St. John’s Hospital – Berryville
- Saint Mary’s Regional Medical Center, Russellville
- Magnolia Hospital, Magnolia
- Northwest Medical Center, Springdale
- Baptist Health Medical Center – Arkadelphia
- Baptist Health Medical Center – Stuttgart
- McGehee Desha County Hospital, McGehee
- Pike County Memorial Hospital, Murfreesboro
- Mercy Hospital/Turner Memorial, Ozark
- North Logan Mercy Hospital, Paris
- Mercy Hospital Scott County, Waldron
- Crittenden Regional Hospital, West Memphis
- Five Rivers Medical Center, Pocahontas
- DeWitt Hospital, DeWitt
- Physician’s Specialty Hospital, Fayetteville
- John Ed Chambers Memorial Hospital, Danville
- Lawrence Memorial Hospital, Walnut Ridge
- Little River Memorial Hospital, Ashdown
- Piggott Community Hospital, Piggott
Winners of the Arkansas Hospital Association’s 2009 Diamond Awards have been selected. The competition, co-sponsored by the Arkansas Society for Healthcare Marketing and Public Relations, is designed to recognize excellence in hospital public relations and marketing.

Diamond, Excellence and Judges’ Merit Awards were possible in three divisions (hospitals with 0-99 beds, hospitals with 100-249 beds and hospitals with 250 or more beds) in 12 categories. The competition drew 135 entries.

The top awards (Diamond) were presented October 8 during the Arkansas Hospital Association’s 79th Annual Meeting and Trade Show Awards Dinner at the Peabody Hotel in Little Rock.

Judging for each entry was based on goals and objectives, audience to whom directed, reasons for choosing the format, frequency and quantity, portions that were created internally/externally, results/evaluation and total budget.

The award-winning hospitals are:

- Arkansas Children’s Hospital, Little Rock
- Arkansas Children’s Hospital Foundation, Little Rock
- Arkansas Hospice, Little Rock
- Arkansas Methodist Medical Center, Paragould
- Baptist Health Medical Center, Little Rock
- CARTI, Little Rock
- Conway Regional Health System
- Crittenden Regional Hospital, West Memphis
- North Arkansas Regional Medical Center, Harrison
- Siloam Springs Memorial Hospital
- St. Bernards Medical Center, Jonesboro
- St. Vincent Health System, Little Rock
- Stone County Medical Center, Mountain View
- UAMS Medical Center, Little Rock
- Washington Regional Medical System, Fayetteville
- White River Health System, Batesville

Congratulations to all the 2009 Diamond Award winners!
Amerinet Introduces Financial Management Solutions

Editor’s Note: Amerinet is an Endorsed Vendor with AHA Services, Inc., which provides cost-saving services for AHA member hospitals. For more information, please contact Tina Creel at 501-224-7878.

Today’s healthcare environment presents new and complex challenges, especially in terms of financial efficiency. These trials can be most apparent with your organization’s understanding of the revenue cycle and how to best manage your processes.

In light of current economic trends, increasing regulatory requirements and competition, tightening margins and wasteful business processes, hospitals and health systems are seeking solutions that help save money now more than ever. These market forces also make it necessary to leverage new ways to improve revenue and charge-capture management to offset losses, pay for capital improvements and increase cash flow.

With this in mind, Amerinet introduced Financial Management Solutions, which enable healthcare providers to identify and implement margin improvement initiatives in each phase of patient interaction. Through assessment, implementation and software, providers can make quantifiable, hard-dollar gains in their financial statements. The solutions provide real answers to difficult issues including implementing technology, eliminating administrative waste, facilitating or enforcing standards and constantly changing payment protocols.

“It is becoming increasingly difficult for healthcare providers across the country – large and small – to institute effective revenue cycle management practices and optimize financial performance,” said Randy Walter, Amerinet executive vice president. “What Amerinet Financial Management Solutions can do is assist facilities in achieving a compelling increase in net cash, with less cost, more patient satisfaction and minimum inconvenience and risk.”

Delivering as much as a 5 percent increase in cash collections, Financial Management Solutions improves an organization’s bottom line by offering access to aggressive automation and a modern operating model, so healthcare providers will not only see better recovery with accounts receivable (AR), but will realize more work is accomplished with fewer employees and more productivity.

Amerinet’s Financial Management Solutions allow providers to:
- Increase net revenue
- Increase net collection percentage
- Reduce the cost of collections
- Make cash flow more predictable

As a vital component of Amerinet Financial Management Solutions, the Amerinet Alliance for Financial Efficiency was formed to fill a growing need in the healthcare marketplace to reduce costs, improve revenue management and optimize financial efficiency.

“To meet today’s challenging trends of increasing self-pay and uninsured patients, ever-changing regulatory requirements, competition and tightening margins, Amerinet has created an alliance of market-leading companies providing best-of-class revenue cycle and financial performance improvement solutions that support hospitals of all sizes – quickly, cost-effectively strengthening financial performance,” said Walter. “Joining with Craneware and Perot Systems to form the Amerinet Alliance for Financial Efficiency offers our members the most effective approach to end-to-end revenue cycle management and financial performance improvement.”

The Alliance’s best-in-class software, services and support focus on specific areas encompassing: scheduling, pre-registration, patient access and estimates, charge capture, coding, utilization, collection, accounts receivable management and remittance processing. Supply management solutions include the industry’s first and only pharmacy supply application that connects siloed pharmaceutical purchasing and billing information for improved charge capture, pricing and cost management.

Amerinet also provides education on financial management solutions and CE credits for more than 30 different disciplines through its education division, Inquisit. Inquisit supports the professional growth and development of healthcare executives, managers and staff by providing high quality, cost-effective educational seminars and workshops accessible in a variety of ways, including online and live learning opportunities. To access any of their programs or learn more, visit www.inquisit.org.

Information on these or any of the other products and services from Amerinet that can help you reduce costs and improve quality are available by calling Customer Service at 877-711-5700, visiting www.amerinet-gpo.com, or the AHA Services, Inc. Web site at http://www.ahaservicesinc.com.
Editor’s Note: This article first appeared in the May issue of Health Care Labor Report (HCLR). In late July 2009, news media reported that key Senate proponents of the Employee Free Choice Act (EFCA) proposed to drop the provision of the bill allowing a union to become certified only on the basis of majority sign-up (card check), while leaving other provisions of the bill intact. Though this article may seem to focus solely on the card check issue, in reality it focuses on all the labor relations standards included in the bill.

Mark Thomas, Vice President of human resources and organizational development at Greater Baltimore Medical Center.

Having been through a number of organizing campaigns and elections throughout his career, Mark Thomas, vice president of human resources and organizational development at Greater Baltimore Medical Center (GBMC), has learned many lessons. The most important, “You have to be prepared. In order to avoid an organizing campaign or come out of a campaign successfully, you have to think ahead and plan for it. One of the ways we have done this is by incorporating our labor relations strategy into our overall Human Resources strategic plan. A successful strategy means adopting the same mentality and level of preparedness for labor relations as for any other major employee relations initiative.”

HCLR: Mark, tell us a little bit about Greater Baltimore Medical Center.

Thomas: GBMC is a 335-bed acute and subacute care facility employing 2,500 employees, 1,100 of whom are RNs. We handle about 26,700 inpatient cases and 60,000 emergency room visits annually. We have 1,300 physicians on our medical staff. About 420 of our service workers have been represented by the SEIU since the early 1980s.

HCLR: What is “ground zero” for this positive employee relations focus and philosophy?

Thomas: I’d say there are three key parts: (1) education and awareness of issues that can impact the organization and our employees; (2) opportunities to hear from employees, solicit their input and act on that input; and (3) a communications policy that sets expectations and procedures and, therefore, conveys the importance and value we place on communicating effectively between employees and managers.

HCLR: With the Employee Free Choice Act (EFCA) – or some version of it – likely to be enacted before the end of the year, what is GBMC doing to prepare?

Thomas: Actually, our strategy has been ongoing for quite some time and is not necessarily tied to the fate of EFCA, though recently we have increased our focus on that and other labor issues. We have incredibly strong support from our board, executive team and medical staff for our positive employee relations initiative. Though not solely focused on labor by any stretch, this initiative has the added benefit of creating a work environment that we believe makes our employees less susceptible to potential organizing efforts.

HCLR: In terms of education and awareness about EFCA and other labor issues, what information is being shared and what stakeholder groups are you trying to reach?

Thomas: We are reaching out to everyone from the board to our employees. Our board – which has been fully educated on EFCA and its potential impact on the organization, our patients...
We have incredibly strong support from our board, executive team and medical staff for our positive employee relations initiative. Though not solely focused on labor by any stretch, this initiative has the added benefit of creating a work environment that we believe makes our employees less susceptible to potential organizing efforts.

HCLR: What type of response did you get from the physicians? Were they aware of EFCA and its potential impact on GBMC and more specifically, on them?

Thomas: There were a lot of questions and many misconceptions about EFCA – and unions in general – that we were very pleased to be able to discuss with our medical leadership. Having the opportunity to talk about these issues in terms of potential impact on patient care, revenue, workplace dynamics and delivery of service really helped frame the issue and broaden understanding. In fact, the Med Board brought a motion before the group to endorse the Board of Director’s policy, which they did. This has sent a powerful message to the entire organization and helped to cement the support of our physicians for all of our positive employee relations initiatives.

HCLR: In terms of the direct impact of EFCA and/or union organizing on physicians, what were some of the things you shared with them?

Thomas: The issue of most concern to physicians was the possibility of having a disinterested third party (an arbitrator) determining the terms and conditions of employment for the nurses (or other employees) with whom they work. As physicians, they would have little input in decisions that were being made that would directly impact how their co-workers were permitted to perform their job duties and, therefore, interact and collaborate with them. In a healthcare environment where patients’ lives are at stake, this seemed unfathomable. The possibility of a strike or work stoppage also was of great concern given the likely impact on patient care.

HCLR: What about your managers/supervisors? What type of education and training have you provided them on labor issues?

Thomas: We have been very proactive in this regard. They have all received a half-day training that included our new policy, information about the EFCA, card signing, do’s and don’ts, etc. We also have created an Internal Union Avoidance Leader team, which consists of 24 of our most talented frontline managers. These individuals participated in an intensive four-day training that has prepared them to operate as internal consultants on union avoidance and “rapid response team.” The in-depth training covered everything from the National Labor Relations Act and the legal aspects of organizing to how to “read” people and determine where their sentiments lie. All GBMC managers are assigned to a member of the Internal Union Avoidance Leader team and know that they can go to that person should any type of employee relations issue arise whether labor related or not.

HCLR: Many organizations are still reluctant to talk with employees about EFCA or union organizing, or at least struggle with determining the right time to initiate that dialogue. What has GBMC’s approach been with regard to employee education and awareness?

Thomas: I can understand the natural hesitation to open what many may characterize as a Pandora’s box. That said, having been through several campaigns and elections, and knowing what is likely around the corner with EFCA (expedited elections and possibly giving unions equal access to employees), I would say the time is now to start raising awareness or at the very least letting employees know what the organization’s position is. In my mind, education and knowledge empower the employee to make an informed decision, whether asked to sign an authorization card or vote in an election, or simply to have a conversation with another employee. GBMC is initiating a series of employee forums to ensure that our employees have the information they need to make educated decisions. In addition to reiterating the organization’s Policy on Labor Relations, we will be emphasizing that the union’s primary motive is to generate revenue through dues-paying members and that signing an authorization card gives the union the employee’s power of attorney to act on his or her behalf. We also will be showing all employees the video, “Little Card, Big Trouble” that talks about the pressure that can be exerted on employees through organizers who recruit internal “pushers” to get employees to sign cards.

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The pressures of the economic downturn influence every aspect of healthcare organizations, including the relationships between organized labor and management. Hospitals are facing financial strains from increased numbers of uninsured patients, slowdowns and elective surgeries, and prospects of cutbacks in reimbursement from state and federal payers. The American Hospital Association (AHA) reports that 90 percent of U.S. hospitals are making cutbacks to weather the economic storm, and nearly half have reduced staff. Data reported to the U.S. Department of Labor indicate a 40 percent increase in 2008 compared to 2007 in the number of hospitals making layoffs involving at least 50 staff. Significant cutbacks continued into 2009, and the number of major layoffs in the first quarter of the year was nearly double the number for the same period in 2008.

Hospitals took to previously successful strategies when making decisions about navigating the current healthcare environment, including initiatives and relationships with organized labor. Between January 2008 and March 2009, the AHA asked hospitals and health care systems about any cooperative relationships or other partnerships they had with the unions representing their employees. Slightly over half of the unionized organizations did report some positive aspects of their working relationship with unions. However, unionized organizations represent only 28 percent of all of the organizations participating in the survey, so the sub-group with collaborative relationships was too small to support a statistically valid analysis of specific issues or individual unions. Nevertheless, the open-ended commentary provided by the respondents gives insights into the nature of positive labor-management relationships in hospitals.

No strong consensus emerged about what is the definition of a “successful” relationship with unions. For some respondents, limiting contact between labor and management to periodic contract
negotiations was perceived as a highly successful relationship. However, others measured success in terms of the ability to work closely with union representatives on joint agreements and establishing new work initiatives. To illustrate the principles of IBN, commentators tell the parable of a dispute between two girls over an orange. Each girl takes the position that she wants the whole orange. Their mother resolves their dispute with a compromise by cutting the orange in half and giving each girl a piece. The mother did not realize that one of the girls wanted only to eat the pulp of the orange, while the other girl wanted only to use the peel in baking cookies. The moral of the story: No conflict existed. Had the girls been asked to explain their interests in the orange, each could have been given all of what she wanted.

Researchers evaluated the IBN approach in negotiating healthcare labor contracts in a case study analysis of the 2005 national contract negotiations between Kaiser Permanente and a coalition of unions representing various labor groups. The study found that IBN techniques were useful in reaching mutually satisfying agreements when the parties had shared or complementary interests.

When interests were in greater conflict, more traditional, positional tactics were required to reach resolution. The joint initiatives most frequently reported by hospitals as successful suggest what may be the more complimentary interests of labor and management. In addition, anecdotal evidence suggests that employees are responding to their own pressures from the downturn in the economy. As healthcare workers delay retirement or return to the work force and increasingly shy away from temporary or part-time hours in favor of full-time employment, their personal interests may align more closely with those of their employer.

Whatever forces drive an alignment of the interests of labor and management, IBN techniques may hold promise for exploiting any potential to build positive working relationships and implement viable long-term solutions to complex healthcare delivery issues.

FOOTNOTES


(Editor’s Note: This article first appeared in the June issue of Health Care Labor Report.) © 2009 IRI Consultants, Inc.
Clinical Integration Webinar for Trustees

As the pendulum for the prototypical model of healthcare delivery continues its swing away from stand-alone practices and organizations, hospital executives may find themselves thinking about the need to become more closely aligned with physicians. At the same time, a trend is developing that indicates doctors are approaching hospitals more often to talk about becoming employees, or creating a multi-specialty group. For both groups, these conversations are aimed at negotiating a pathway toward “clinical integration” and successfully becoming an “accountable care organization.”

Knowing that many hospitals need help avoiding obstacles along a road not clearly marked, the Arkansas Hospital Association and the Reinertsen Group have collaborated to present “So You Want to Clinically Integrate with Your Doctors? Have You Signed Your Informed Consent?” from 10:00-11:30 a.m. CST on October 23. Presenters Jim Reinertsen and Jamie Orlikoff will focus on some critical questions that hospital and physician leaders should address when considering the creation of any major moves toward alignment or integration, whether structural or “virtual.” These questions include:

- Why? Why are we doing this? Do we have any sense of common purpose?
- What? What values will be at our core? Will this new entity just be a warmed-over version of the “organized medical staff,” or will it strive to be something better than that?
- Who? Who will we invite to be part of this new “thing”? Will we start with only those who really share the values, or will we invite every possible doctor and then sort out the problems later?
- When? How long is this going to take? Can we put something valuable together in the next year or so, or will this take 50-100 years like the Mayo Clinic?
- Where? Where is all of this headed? Are we going to be a hospital that “owns” doctors’ practices, or a multispecialty medical group that happens to have an acute care facility as part of it, or....?

Medical staff leaders, hospital executives and board members in the middle of conversations about “clinically integrating,” who feel uneasy about how your colleagues would answer any of these questions, are invited to join in for this important Web seminar. For registration information, please click on http://www.arkhospsitals.org/calendaraudio.htm.

Employee Benefits
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For more than 30 years, the professionals of Hagan Newkirk have partnered with healthcare providers throughout Arkansas to make administering employee benefits simple. With our online enrollment and HR management systems, ALL your benefit information is just a key stroke away.
Survey: Recession Causing Workers to Forgo Healthcare Treatment

More than a quarter of workers are skipping healthcare treatment to save on co-pays and co-insurance, according to a survey released this summer by the National Business Group on Health.

An executive summary of the survey, titled “The Recession’s Toll on Employees’ Health,” was first presented by Helen Darling at the National Press Club May 27.

The survey indicates that among the 1,500 insured workers at large companies (2,000 or more employees) surveyed, 20 percent said they skipped taking medications, and 17 percent said they had split a dosage in half to save money.

In addition, 68 percent said having access to health benefits is a key reason for staying with their employer, while 52 percent considered cost to be the most important factor when choosing a health plan.

A link to the survey’s executive summary and Darling’s presentation is available at [http://www.businessgrouphealth.org/benefitstopics/topics/nbghpubs.cfm](http://www.businessgrouphealth.org/benefitstopics/topics/nbghpubs.cfm), scroll down to May 27 and click on The Recession’s Toll on Employees’ Health Executive Summary.

HUD Section 242 Extended to Offer Hospital Mortgage Refinancing Opportunity

The Federal Housing Administration (FHA) has announced that it is implementing its authority under section 223(f) of the National Housing Act to provide, in conjunction with financing under Section 242 of the National Housing Act, refinancing of debt for hospitals, without conditioning such refinancing on new construction or renovation, as is the current program requirement.

In addition, the Department of Housing and Urban Development will be publishing a rule that proposes to amend the regulations in 24 CFR part 242 to incorporate the provisions applicable to Section 223(f) refinancing as presented in this notice, and therefore make refinancing under Section 223(f) a permanent component of the Section 242 Hospital Mortgage Insurance Program.

FHA encourages review and comment on that rule, which incorporates the provisions of the FHA notice. For more information, see [http://www.hud.gov/offices/adm/hudclips/notices/hsg/files/09-05hsgn.doc](http://www.hud.gov/offices/adm/hudclips/notices/hsg/files/09-05hsgn.doc).

AHA Continues “2 for 1” Registration Offer

Due to the overwhelming response, comments by attendees as well as hospital CEOs, and the continued state of our economy, the Arkansas Hospital Association (AHA) will continue to honor the “two for the price of one” registration fee on all but a few workshops through the end of 2009.

Since the time we instituted this new policy in March, 88 individuals have taken advantage of the opportunity to attend an AHA workshop along with one of their peers – both for the price of one fee.

All program brochures will clearly state whether or not the two-for-one offer applies to that particular workshop. It is our hope that this offer will introduce more hospital employees to the types of quality educational programming offered by the AHA.

Educational program brochures may be accessed at [http://www.arkhospitals.org/calendareducworkshops.htm](http://www.arkhospitals.org/calendareducworkshops.htm).

Members should also take advantage of the Webinars and audio conferences which the AHA offers each week on a wide variety of topics. A list of current offerings may be found at [http://www.arkhospitals.org/calendaraudio.htm](http://www.arkhospitals.org/calendaraudio.htm).

Please check this site often as new programs are added on an almost daily basis.

If you have questions or comments about the AHA education program, please contact Beth Ingram at (501) 224-7878 or bingram@arkhospitals.org.
Web Eases Access to Nursing Discipline Reports

The Arkansas State Board of Nursing (ASBN) has offered an option that could make it easier for hospitals and other healthcare providers to obtain disciplinary information tied to nurse licenses in the quickest manner.

ASBN executive director Faith Fields informed the Arkansas Hospital Association recently that the Board often cannot respond to all Freedom of Information requests in the most timely manner due to the volume of requests it receives.

Fields suggests that hospitals needing the information in a shorter time frame might go to a Web site hosted by the National Council of Boards of Nursing. By accessing www.nursys.com, requests about pertinent disciplinary information can be available within a matter of minutes at no cost.

The Web site provides general and detailed information regarding nurse licensure and disciplinary history. Healthcare providers, employers and the general public can retrieve the information and print it out.

To find the information, go to the Web address above and follow these steps:

- Click on “Licensure Quick Confirm”
- Read the disclaimer and check “I Agree”
- Enter license number, license type and jurisdiction. If the license number is unknown, search by name by clicking “Search.”
- When the nurse’s name, license number and jurisdiction appear on the center of the page, check “Select License” or “Select Individual.” Enter the text that appears (usually four digits) into the white box and click “Generate Verification Report.”

The resulting report will show all available disciplinary action, including: basis for the action, action taken against the license, a narrative explaining the specifics of each disciplinary action and whether the discipline is against the license and/or the privilege to practice.

2009 Data Issue of Arkansas Hospitals Magazine Now Available

Each year, the Arkansas Hospital Association dedicates the summer issue of its quarterly publication, Arkansas Hospitals, to covering a broad range of statistical and other information concerning the state’s hospitals.

The 2009 edition of the magazine has been distributed to all AHA members and other subscribers.

This magazine is a readily available and useful resource that can help hospital leaders communicate about utilization trends and the financial strength of the state’s hospital community, as well as its impact in area economies, social structures and care-giving networks.

It helps to explain a hospital’s financial situation to those who don’t understand today’s challenges and can help to form a base of discussion for visits with groups ranging from local civic organizations to elected officials.

The Summer 2009 issue of Arkansas Hospitals can be a valued resource in communicating the hospital story and is available at http://arkhospitals.org/arkhospmagpdf/AHASummer09.pdf.

CDC Launches Public Health Tracking Web Site

The Centers for Disease Control and Prevention (CDC) has launched a Web-based tool that allows scientists, health professionals and members of the public to track environmental exposures and chronic health conditions. Known as the National Environmental Public Health Tracking Network, the site brings together environmental information from across the country – including air and water pollutants, as well as information for certain chronic conditions, including asthma, cancer, childhood lead poisoning and heart disease – in one resource.

“The ability to examine many data sets together for the first time has already resulted in faster responses to environmental health issues,” said Howard Frumkin, director of the CDC’s National Center for Environmental Health, in a news release. “We believe the tracking network holds the potential to shed new light on some of our biggest environmental health questions.”

According to the CDC, the Atlanta-based agency funds projects in 17 states that have led to 73 public health actions to control potential illnesses from environmental exposures. In March, the CDC received additional funding from Congress to expand environmental public health tracking to five more locations. The agency said it hopes to eventually expand the tracking network to all 50 states.

You may access the site at http://ephtracking.cdc.gov/showHome.action.
Grants for Health Careers Preparation Available

Secretary of Labor Hilda L. Solis has announced a $220 million competition to fund projects that prepare workers for careers in healthcare and other high growth industries.

Grants awarded through this competition will be funded under the American Recovery and Reinvestment Act of 2009 and are intended to fund public entities and private, nonprofit organizations to train individuals for careers in nursing, allied health, long-term care and health information technology.

Training also will be provided for careers in other growing industries based on specific regional needs. A notice of the grant solicitation was included in the July 22 edition of the Federal Register, and it will be available at http://www.doleta.gov/grants/find_grants.cfm and http://www.grants.gov.

The notice may be viewed online at http://www.federalregister.gov/inspection.aspx.

Guidelines for Communicating Financial Obligations

The Patient Friendly Billing Project has developed new guidelines to help hospitals better communicate with patients about their financial obligation at the earliest point possible in the care experience.

The guidelines should help providers gather information before and at the time of service so that they can prospectively estimate patients’ expected out-of-pocket costs and determine for what financial assistance patients may be eligible.

The Patient Friendly Billing Project, spearheaded by the Healthcare Financial Management Association with support from the AHA and others, promotes clear, concise and correct patient-friendly financial communications.

Click on http://www.hfma.org/library/revenue/PatientFriendlyBilling/ETFRec.htm to view the guidelines.

Arkansas Medicaid Distributes IQI Payments

On June 30, 2009, the Arkansas Medicaid program completed the third year of its nationally recognized Inpatient Quality Initiative (IQI), a type of pay-for-performance program designed to tie incentive-based payments to hospital performance in meeting select quality thresholds. During State Fiscal Years (SFY) 2007 and 2008, qualifying hospitals received a combined $8.8 million in bonuses. For SFY 2009 more than $3.5 million will be paid out to 24 Arkansas hospitals that qualified for the incentive payments. In addition, three Critical Access Hospitals, which are not eligible for the incentive payments, qualified for recognition by meeting the quality thresholds.

Originally established in July 2006, the Arkansas Medicaid IQI Program rewards eligible hospitals which meet certain pre-established quality thresholds. The IQI bonus payments are made in addition to the hospital’s traditional inpatient reimbursements and amount to 5.8% hospital per diem, up to $50 per day, for each Medicaid-paid day for patients over one-year-old during the fiscal year period. Qualifying hospitals must meet or exceed Medicaid’s required compliance rate on two-thirds (66.7%) of the quality measures for the reporting period. Those measures are determined by state Medicaid officials in conjunction with representatives of the Arkansas Foundation for Medical Care, the state’s Medicare Quality Improvement Organization, and a committee composed of quality review professionals from Arkansas hospitals.

For SFYs 2007 and 2008, the Medicaid quality measures reflected a similar subset of pneumonia and heart failure measures that were already a part of the Hospital Quality Alliance reporting program for Medicare, although the thresholds to qualify for the added payments were tweaked for SFY 2008 to raise the bar on hospitals’ level of achievement and validation scores. The quality measures for SFY 2009 continued to be based on a subset of Medicare’s pneumonia and heart failure care processes, but also included a state-specific indicator designed to address quality issues related to transition of care and patient handoff processes.

The Arkansas Hospital Association plans to host a formal recognition ceremony for recipient hospitals in October. Details for that ceremony are not yet finalized.
Just as Arkansas hospitals are bracing for the advent of Medicare Recovery Audit Contractor (RAC) audits, providers also must prepare for an increase in Medicaid audits as a result of the newly implemented Medicaid Integrity Program (MIP).

Although a great deal of information about the RAC program is available to the provider community, the MIP has proceeded virtually unnoticed under the radar. Not much is known about the program or its contractors.

Established by the Deficit Reduction Act of 2005, the MIP is the first federal program to perform Medicaid provider audits. Like its RAC cousin, the MIP requires the use of contractors to target providers through the use of statistical data, to audit provider claims and identify potential overpayments, as well as to provide education.

These contractors are known as Medicaid Integrity Contractors (MICs). There are three types of MICs: Medicaid Integrity Review Contractors (Review MICs); Medicaid Integrity Audit Contractors (Audit MICs); and Medicaid Integrity Education Contractors (Education MICs).

Education MICs are charged with educating providers, beneficiaries and others about program integrity. To date, there is little information about Education MIC activity within the state.

More is available about Review and Audit MICs. The Review MIC for CMS Region VI, which includes Arkansas, is AdvanceMed. As a Review MIC, AdvanceMed performs data mining and analysis using computer algorithms to look for potentially inappropriate Medicaid payments or fraud.

That information then provides leads to the Audit MIC for use in targeting providers for audit. The Audit MICs are the most hands-on contractors, conducting post-payment desk audits and field audits after providers have been identified by the Review MIC or the state Medicaid program.

The Audit MIC for Arkansas is Health Management Systems (HMS), and its audits of Arkansas Medicaid providers have already begun. Available information indicates that HMS is auditing only fee-for-service claims currently, but there are plans to add cost report audits at a later date.

HMS, as the Audit MIC, will request medical records and additional supporting documentation for Medicaid claims.

Unlike RACs, there seems to be no limit on the number of medical records that MICs can request and no right to reimbursement for copy charges. In addition, there is no limited “look back” period. Audit MICs can request records as far back as the state Medicaid agency could request in a similar audit.

Also, after completion of an audit, the MIC is not responsible for collecting overpayments directly from providers. Instead, the state Medicaid program will recover the identified overpayments, and the federal government will collect its share of the recovered funds from the state.

All provider appeals of Audit MIC decisions will be handled through the state Medicaid agency’s normal appeals process.

According to an April 2009 Government Accountability Office (GAO) report, the Medicaid program reported an estimated error rate of 10.5 percent with a total improper payment estimate of $32.7 billion ($18.6 billion in federal money and $14.1 billion in state money).

With these dollar amounts at stake, MIC audits could have a significant impact on providers.

The AHA is working to acquire additional information about the MIP and related MIC activities in Arkansas and will host an October 21 audioconference about the MIP and MICs to include presentations from CMS and representatives from Arkansas Medicaid.
RAC Readiness Manual Now Available

For well over a year, the AHA has been assisting our members in preparing for RAC audits. To further help hospitals meet this challenge, the AHA is pleased to announce a partnership with the Georgia Hospital Association to offer the RAC Readiness Manual—a comprehensive guide to the audit process and hospital preparations.

The manual provides helpful information for organizing and conducting your RAC audit preparation process and includes helpful analysis and guidance, as well as practical tools.

We are confident that the manual will serve as an essential tool in helping hospitals plan and prepare for RAC audits.

This eight-chapter guide covers everything from preparing for RAC initiatives to education of hospital board members, executives and staff.

The guide also includes templates for setting up your RAC team, practical tools for assessing your hospital's operations, a questionnaire that can be used in evaluating your hospital's RAC readiness from a process perspective, legal issues involved, how to respond to RAC inquiries, and other issues applying specifically to Arkansas law and Arkansas hospitals.

The RAC Readiness Manual also includes various appendices and exhibits, including CMS documents, AHA Advisories, CCA information and Web site resources.

Copies of the RAC Readiness Manual are available for the low price of $125 each. A complete listing of the guide's contents and an order form for the manual are available on the AHA Web site, www.arkhospitals.org, click on the upper tab titled RAC; then scroll to the bottom of the resource list.

HHS Rescinds Medicaid Regulations

Department of Health and Human Services (HHS) Secretary Kathleen Sebelius in late June announced that the administration will rescind all or part of three Medicaid regulations that were previously issued and delay the enforcement of a fourth regulation.

Each of these rules, in whole or in part, had been subject to Congressional moratoria set to expire on July 1, 2009. The actions, which are supported by the American Hospital Association, include:

- Rescinding a final rule, published December 28, 2007, that would have eliminated reimbursement for school-based administrative costs and costs of transportation to and from schools. The rescission reflects concern that the rule could limit the Medicaid administrative outreach activities of schools, and that the overall budgetary impact on schools could potentially impact their ability to offer Medicaid services to students.
- Rescinding a rule, published November 7, 2008, that would have limited the outpatient hospital and clinic service benefit for Medicaid beneficiaries to the scope of services recognized as an outpatient hospital service under Medicare. This rule was rescinded because CMS became aware that coverage beyond that scope could not be easily moved to other benefit categories, resulting in greater impact than previously anticipated.
- Rescinding provisions of an interim final rule published December 4, 2007, which would have restricted beneficiary access to case management services. These provisions appeared to, in practice, restrict beneficiary access to needed covered case management services, and limit state flexibility in determining efficient and effective delivery systems for case management services.
- Delaying until June 30, 2010, the enforcement of portions of a regulation that clarified limitations on healthcare-related tax programs so that CMS could determine whether states need additional clarification or guidance. CMS may also further review the potential impact of the regulation and give additional consideration to alternative approaches.
RAC Announces Automatic Audits

Connolly Consulting, the Medicare recovery audit contractor (RAC) for Region C, issued an August 4 announcement concerning seven automatic audits, including hospital outpatient codes, which have begun in South Carolina.

The RAC, which covers 16 states and territories including Arkansas, is expected to issue demand letters in South Carolina that will notify hospitals of coding errors and the related dollar amount per claim that will be recouped.

Hospitals in every RAC region should identify a primary point of contact that should register with their RAC.

The specific codes targeted are listed online at http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx.

Arkansas had its RAC hospital outreach workshop, which included representatives from CMS and Connolly Consulting, on September 3. This was the most widely-attended workshop in AHA history with almost 400 participants.

Hospitals in every RAC region should identify a primary point of contact that should register with their RAC.

For more on the RAC program, including recordings of prior education sessions and recommendations on how to prepare for RAC audits, visit www.aha.org/rac.

Contact information for Connolly and the other regional RACs is available at http://www.cms.hhs.gov/RAC/Downloads/RAC%20Contact%20Information.pdf.

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No RAC Medical Necessity Reviews Until 2010

The Centers for Medicare & Medicaid Services (CMS) does not expect its Medicare recovery audit contractors (RAC) to conduct complex reviews for medical necessity of hospital services until 2010, according to agency officials.

For this type of review, a RAC retroactively reviews a Medicare claim to determine if services provided to a beneficiary were medically necessary as defined by Medicare guidelines in effect at the time of service.

During CMS’ three-year RAC demonstration, 32 percent of all claims denials were for medical necessity. However, a CMS-sponsored study of medical necessity denials of inpatient rehabilitation facility claims performed by the California demonstration RAC found a 40 percent error rate.

Rochelle Archuleta, the American Hospital Association’s senior associate director for policy, commented that the study validated concerns about the ability of RAC auditors to accurately judge the clinical decisions made by a patient’s treating physician – sometimes three or more years after the care was provided. The concerns persist with regard to the permanent RAC program, which has a look back period of three years, although RACs may not review claims paid prior to October 1, 2007.

New Medicare Secondary Payer Reporting Requirements

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 created new reporting requirements that will apply to many hospitals under the Medicare Secondary Payer (MSP) law.

Hospitals that self-insure (as defined by MSP) their liability or self-fund a workers’ compensation plan or a group health plan may be subject to the new reporting requirements.

If a hospital is subject to the new requirements, the information required and the logistics for reporting likely will require new reporting processes and coordination across the organization.

For MSP purposes, there is a unique definition of self-insurance. A hospital will need to examine its practices using MSP guidance, in particular whether it makes payments for the deductible or self-pay portion of a liability insurance policy directly to an individual who makes a claim, rather than to the insurer.

Hospital Compare Adds Readmission Rates to Web Site

The latest update of the Hospital Quality Alliance’s Hospital Compare Web site (www.hospitalcompare.hhs.gov) includes, for the first time, data on hospital readmission rates for Medicare patients treated for heart attack, heart failure and pneumonia.

The newest version of Hospital Compare went public July 10.

Based on Medicare billing records from July 2005 to June 2008, the data show how often patients with each of these conditions return to the same or a different hospital within 30 days of discharge, and how each hospital’s readmission rates compare to the average rates for the state and nation.

Hospitals can use the data to investigate factors that may contribute to hospital readmissions, such as a lack of primary and hospice care or transportation challenges for patients getting to follow-up appointments.

The transparency Web site also was updated with the latest data on 30-day mortality rates for patients hospitalized with a principal diagnosis of heart attack, heart failure and pneumonia.
Healthcare-associated infections (HAIs) have received increasing attention since the Institute of Medicine published its landmark 1999 report¹ highlighting the impact of HAIs on patients. An HAI is defined as an infection that was not present or incubating in the patient at the time of admission to a healthcare facility.

According to the Centers for Disease Control and Prevention, HAIs account for more than 1.7 million infections and 99,000 deaths annually and affect 5 percent to 10 percent of hospitalized patients.² Estimates of the overall annual direct medical costs to U.S. hospitals of all HAIs range from $28.4 billion to $45 billion.³

The most common site-associated HAIs are catheter-associated urinary tract infections (UTI), central line-associated bloodstream infections (CLABSI), surgical site infections and ventilator-associated pneumonia (VAP). Organism-specific pathogens that are increasing in number and contributing to the cost of HAIs include methicillin resistant Staphylococcus aureus (MRSA), clostridium difficile (C. diff.) and extended spectrum beta-lactamase-producing gram negatives. Urinary tract infections are by far the most common, and bloodstream infections are the most costly. (See table.)

As the national focus on HAIs has intensified, Arkansas has also increased its efforts to reduce HAIs. In 2007, the Arkansas legislature reviewed a bill that would have mandated infection reporting by Arkansas hospitals. During that legislative session, however, the direction changed from mandated to voluntary reporting of a specific list of healthcare-associated infections by hospitals and ambulatory surgery centers. Act 845 of 2007 created a task force, under the oversight of the Arkansas Department of Health, that was charged with determining the logistics of compiling reports for the state. Importantly, the act specifies that any data released publicly must not identify any specific health facility, patient, employee or healthcare professional.

It was decided that the Arkansas reporting initiative would use the CDC’s National Healthcare Surveillance Network (NHSN), a national data bank for infection reporting. This will provide a means for reporting and could also provide national benchmarking for hospitals in Arkansas.

In August 2008, the Centers for Medicare & Medicaid Services (CMS) began the ninth Scope of Work, which included a component for recruiting hospitals to report MRSA data to the NHSN. The Arkansas Foundation for Medical Care was charged with recruiting two hospitals to report data and reduce MRSA through targeted strategies. Thirteen Arkansas hospitals signed up to participate.

Further, in January 2009, CMS began requiring that hospitals use “present on admission” coding for certain infectious conditions, includ-

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### Estimated Annual Hospital Cost of HAI by Site of Infection

<table>
<thead>
<tr>
<th>Major Site of Infection</th>
<th>Total Infections</th>
<th>Hospital Cost Per Infection (2002 Dollars)</th>
<th>Total Annual Hospital Cost (in Millions)</th>
<th>Deaths Per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical site infection</td>
<td>290,485</td>
<td>$25,546</td>
<td>$7,421</td>
<td>13,088</td>
</tr>
<tr>
<td>Central line-associated bloodstream infection</td>
<td>248,678</td>
<td>$36,441</td>
<td>$9,062</td>
<td>30,665</td>
</tr>
<tr>
<td>Ventilator-associated pneumonia</td>
<td>250,205</td>
<td>$9,969</td>
<td>$2,494</td>
<td>35,967</td>
</tr>
<tr>
<td>Catheter-associated urinary tract infection</td>
<td>561,667</td>
<td>$1,006</td>
<td>$565</td>
<td>8,205</td>
</tr>
</tbody>
</table>


SOURCE: U.S. Department of Health and Human Services
Interventions focused on a central line bundle, which has five components: hand hygiene, maximal barrier precautions, chlorhexidine skin antisepsis, optimal catheter site selection (the subclavian vein is the preferred site for non-tunneled catheters in adults), and daily review of line necessity. Thirty-four Arkansas hospitals have joined the AHA’s “Stop BSI” project, which kicked off in July.4 The aim of the project, which is being conducted in conjunction with the Johns Hopkins Research and Safety Group and led by Peter Pronovost, MD, PhD, is to dramatically improve patient safety, quality and costs by reducing CLABSI rates. Arkansas’ project hopes to replicate the success of the Michigan Health & Hospital Association’s Keystone Project, which lowered that state’s CLABSI rate to nearly undetectable over five years. The Stop BSI project recognizes that patient safety should be approached in the same way as curing a disease – through rigorous scientific research that produces hard data with clear, measurable results.5

The project has a technical component, which provides concise evidence-based recommendations on how to address a specific clinical challenge, and an adaptive component, which provides a framework for patient safety improvement at the local unit level. Specific interventions in the project will include: educating staff on evidence-based practices to reduce CLABSI; creating a standardized central line checklist based on these practices; empowering nurses and other staff members to improve communication and ensure effective use of the checklist; and holding monthly team meetings to assess progress. Data will be collected from participating hospitals monthly.

During the course of the two-year project, the AHA will act as the liaison between the hospitals and Johns Hopkins, and AFMC will provide monetary and other support. Clinical personnel will interact with local teams through conference calls and workshops in Little Rock.

Arkansas hospitals have enthusiastically embraced HAI projects and reporting and will continue to do so as new initiatives present themselves. As AFMC, AHA and the Arkansas Department of Health continue to support providers and hospitals in their efforts, we expect to see improved care for all Arkansas patients. For more information, contact Pamela Brown at 501-212-5310 or Elisa White at 501-224-7878.

References
4. Participants in the Arkansas “Stop BSI” project as of July 23, 2009: Allegiance Specialty Hospital of Little Rock, Arkansas Heart Hospital, Arkansas Methodist Medical Center, Ashley County Medical Center, Baptist Health Extended Care, Baptist Health Medical Center-Heber Springs, BHMC-Little Rock, Bradley County Medical Center, Conway Regional Medical Center, Crittenden Regional Hospital, Cross Ridge Community Hospital, Drew Memorial Hospital, Five Rivers Medical Center, Lawrence Memorial Hospital, Mercy Medical Center, NEA Baptist Memorial Hospital, North Arkansas Regional Medical Center, North Metro Medical Center, Ouachita Medical Center, Ozark Health Medical Center, Saline Memorial Hospital, St. Bernards Medical Center, St. Joseph’s Mercy Health Center, UAMS Medical Center, Washington Regional Medical Center, White County Medical Center, White River Medical Center.

This article was originally published in the October 2009 issue of the Journal of the Arkansas Medical Society.
Dr. Peter Pronovost Hosts Arkansas’ First Face-to-Face “Stop BSI” Project Workshop

Dr. Peter Pronovost, who currently leads the Stop BSI project in the United States, and who led the Michigan Keystone Project that was the forerunner of this initiative, was the featured presenter at Arkansas’ first face-to-face meeting of those participating in the state’s “Stop BSI” (Bloodstream Infections) project.

Dr. Pronovost is an internationally renowned expert in the fields of patient safety, quality healthcare and evidence-based medicine. He currently chairs The Joint Commission’s ICU Advisory Panel for Quality Measures and the ICU Physician Staffing Committee for the Leapfrog Group, serves on the Quality Measures Work Group of the National Quality Forum and is an advisor to the World Health Organizations’ World Alliance for Patient Safety.

The project began July 7 with the first of a series of educational calls, recordings of which are available at no charge on the project’s dedicated Web site, www.safercare.net. However, the real “hands on” work began after the project’s first face-to-face meeting, which took place in Little Rock August 27. The meeting was well-attended and generated interest not only from Arkansan hospitals but also from the Arkansas Foundation for Medical Care (AFMC), which provided financial support for the meeting, and the Arkansas Department of Health.

The following thirty-four Arkansas hospitals have joined the Arkansas Hospital Association’s “Stop BSI” project:

- Allegiance Specialty Hospital of Little Rock
- Arkansas Heart Hospital
- Arkansas Methodist Medical Center
- Ashley County Medical Center
- Baptist Health Extended Care Hospital
- Baptist Health Medical Center – Arkadelphia
- Baptist Health Medical Center – Heber Springs
- Baptist Health Medical Center – Little Rock
- Baptist Health Medical Center – North Little Rock
- Baptist Health Medical Center – Stuttgart
- Baxter Regional Medical Center
- Bradley County Medical Center
- Conway Regional Medical Center
- Crittenden Regional Hospital
- CrossRidge Community Hospital
- Drew Memorial Hospital
- Five Rivers Medical Center
- Lawrence Memorial Hospital
- Mercy Medical Center
- NEA Baptist Memorial Hospital
- North Arkansas Regional Medical Center
- North Metro Medical Center
- Ouachita County Medical Center
- Ozark Health Medical Center
- Saint Mary’s Regional Medical Center
- Saline Memorial Hospital
- St. Bernards Medical Center
- St. Edward Mercy Medical Center
- St. Joseph’s Mercy Health Center
- Stone County Medical Center
- UAMS Medical Center
- Washington Regional Medical Center
- White County Medical Center
- White River Medical Center

As they implement the initiative’s programs, the teams from these participating hospitals will begin coaching calls with Johns Hopkins personnel in October. For more information on the project contact Elisa White at (501) 224-7878 or elisawhite@arkhospitals.org.

BSI Program Labeled “Model” Initiative

Announcing the first in a series of reports on model health reform initiatives, Health and Human Services Secretary Kathleen Sebelius has called the Michigan Keystone ICU Project an example of “how health reform can improve the quality of care for all Americans.”

The partnership between the Michigan Health & Hospital Association and Johns Hopkins University resulted in Michigan hospitals saving an estimated 1,500 lives and $175 million per year by voluntarily participating in the evidence-based program to reduce catheter-associated bloodstream infections (BSIs).

This is the same infection reduction project now being replicated in 28 other states, including Arkansas, where 34 hospitals and the Arkansas Hospital Association have begun working in conjunction with Johns Hopkins to implement a similar program.
Pressure Ulcer Prevention: Who’s Responsible?

Pressure ulcers are a common and costly problem in the United States. According to the Association for Healthcare Research and Quality (AHRQ), an estimated 503,000 people were hospitalized for treatment of pressure ulcers in 2006, up almost 80 percent from 1993. The related costs are enormous, both in terms of patients’ health and quality of life and financially: The cost for hospital stays where a diagnosis of pressure ulcer was noted was estimated at $11 billion in 2006, according to AHRQ estimates.

Evidence-based research supports the finding that the majority of pressure ulcers can be prevented with a multidisciplinary approach to ensure prevention practices are in place. However, estimating the percentage of pressure ulcers that could be prevented is difficult because the current healthcare system does not have a means to measure whether all preventive steps were taken.

The Centers for Medicare & Medicaid Services (CMS) launched two national efforts last fall that demonstrate the importance of clinical measurement for a number of health problems, including pressure ulcers. The National Patient Safety Initiative (NPSI), which is contracted through the Arkansas Foundation for Medical Care and other Medicare Quality Improvement Organizations around the country, emphasizes cross-setting collaboration to improve overall patient safety through continuity of care. The second CMS effort is the creation of a list of “never events” to spotlight errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients — including hospital-acquired pressure ulcers. Since Oct. 1, 2008, Medicare has refused to pay for the additional costs of treating never events.

Because Medicare beneficiaries’ healthcare needs are often complex, however, the basics of pressure ulcer prevention can easily be lost in the shuffle. This complexity of care leads to the question, “Who is responsible for preventing pressure ulcers?” The answer is to create a culture of safety where everyone assumes responsibility, understands their roles, and returns to the basics of prevention.

In 1992, the Agency for Health Care Policy and Research (AHCPR) released a pressure ulcer prevention guideline that established a national standard of care. The AHCPR (now known as the Agency for Healthcare Research and Quality [AHRQ]) remains a clinically relevant guideline today and should serve as the foundation for pressure ulcer prevention for every healthcare provider.

The standard of practice to prevent pressure ulcers starts with the use of a validated risk assessment tool that measures primary risk factors for acquiring a pressure ulcer.

The AHCPR guidelines recognize two tools as validated: the Braden Scale and the Norton Scale. These scales should be completed upon admission and at appointed intervals thereafter. Generally, the risk assessment tool is completed with the initial nursing assessment; however, the results should be shared immediately with the appropriate disciplines and physician to ensure a prevention plan of care is implemented. The Braden and Norton scales align with the primary risk factors that are identified in the AHCPR prevention guideline, which are activity/mobility deficits, moisture/incontinence and nutritional deficit.

Prevention practices must be aligned with each patient’s primary risk factors. For example, if a patient is identified to be at risk for a pressure ulcer due to immobility, a culture of safety is missing if the physician’s order simply includes “turn every two hours.” Knowing who is at risk is just the starting point for a comprehensive plan for prevention. In order to meet the needs of a patient who has a risk factor due to immobility, the minimal basics of prevention include:

- An individualized turning schedule (every two hours is a starting guide)
- Pressure redistribution mattress/cushion while in and out of bed
- Complete pressure relief on the heels
- Devices to keep bony prominences from direct contact
- Appropriate positioning off the trochanter

An at-risk patient should have a daily skin inspection to assess for

continued on page 38
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the presence of a stage I pressure ulcer. The presence of a stage I pressure ulcer is the first indication that the plan of care for immobility is not meeting the needs of the patient. Although the “never events” designation applies to the development of the more severe stage III and IV ulcers, providers must keep in mind that even the most severe pressure ulcer began as a stage I.

To physicians, these measures may seem like more barriers to providing good care. However, they were carefully designed with the goal of improving outcomes, not creating burdens for the clinician. Providers should evaluate their own system of care and create a process that can address the pressure ulcer measures, as well as other new measures. As busy clinicians may not have time to do complete surveys for pressure ulcer evaluation, the AHCPR guidelines can be incorporated as standing orders on all admissions and discharges. Some institutions have laboratory surveillance systems in place to identify high-risk individuals with low albumin.

Past endeavors that have shown some success include “turn teams” that target at-risk patients. A select group of caregivers can be organized into a “turn team” that can be responsible for preventive pressure ulcer care and sending patient referrals to the staff enterostomal nurse. The “turn team” can simply function as an extension of the physician to guide care. The goal is a culture of safety to reduce never events and pressure ulcers, not simply to point the finger and imply that a pressure ulcer occurred under another institution’s care.

The ability to implement this plan depends, of course, on the size of the institution, patient comorbidities and average length of stay. To avoid disparities, formal training for patient care technicians is crucial. Cross-training can also allow for time constraint issues, such as bath teams, etc. An emphasis on accuracy in documentation can also foster an environment of consistent care among different shifts as well.

Currently, CMS reports Arkansas pressure ulcer quality measures on the Nursing Home Compare Web site at www.medicare.gov/NHcompare (see Figure 1). For the past six years, AFMC has worked closely with long-term care stakeholders to create a pressure ulcer project that emphasizes the basics of prevention. This project has been successfully implemented in other healthcare settings as well. A return to the basics for pressure ulcer prevention has made the AFMC project a “best practice” strategy. In February 2008, CMS released a list of targeted facilities for AFMC to partner with for quality improvement related to cross-setting pressure ulcer prevention for the NPSI. AFMC successfully recruited 92 nursing homes and 24 hospitals from the CMS targeted list to work with as part of the national NPSI. AFMC will continue to work closely with all providers, stakeholders and consumers to reach greater heights in healthcare quality in the coming years.

Carol Compas, RN, BSN, CPHQ, is manager of quality programs for the Arkansas Foundation for Medical Care. Richard Brown, MD, is a hospitalist at Saline Memorial Hospital and a consultant with AFMC.
PANDEMIC FLU PREPARATION

Pandemic Flu and Your Local Hospital

This is a reminder that flu season is just around the corner. We know your hospital has a flu preparedness plan in place, but with novel H1N1 projected to make this flu season potentially overwhelming to any facility, we offer these questions as reminders:

1. Has your chief of staff or medical staff officer met with your hospital’s medical staff to review current CDC H1N1 guidelines?

2. Does your hospital or ED have a hotline number readily known by the public, so that you can screen for flu by phone—hopefully keeping the ED from becoming overcrowded or overwhelmed?

3. Has your medical staff provided screening questions and appropriate responses to those who will be manning these hotlines and/or phone banks? (Messages for keeping the worried well at home, advising those who can wait to be seen by their own physician, and advising those who appear to need to come immediately to the ED or special screening units.)

4. Has your medical staff been asked, “How do you want to handle the situation when flu is rampant and the hospital ED cannot handle all of your night/weekend patients? Is your medical staff prepared to clinically cover nights and weekends off-site during flu season, perhaps in specially designated flu clinics, so that the ED will not become overwhelmed?”

5. What emergency screening and triage plans has your hospital made in the event that flu—whether seasonal or H1N1—becomes rampant in your community? Do you have alternate screening and triage sites planned, away from the hospital ED? What are the plans for staffing and providing resources for these sites?

6. Do you have alternate care sites identified and have plans for both staffing and resourcing these sites?

Many of our hospitals have existing plans in place, based on the SARS, avian flu and swine flu epidemics of the past. Obviously, these plans can be adapted to the current novel H1N1 flu and the wave of flu predicted to hit our country this fall and winter.

This is just a friendly reminder to touch base with your medical staff and make certain everyone is on the same page when it comes to widespread flu in your community.

The Arkansas Hospital Association is preparing a Pandemic Flu Shelf Kit for member hospitals that will include tools for communicating with the public, should flu overtake your community. It will be a useful resource for keeping the public informed and hopefully will help you spread the word about screening individuals by phone, in physicians’ offices, in special flu clinics (if needed), etc. so that we can keep our EDs open for non-flu emergencies.

The Arkansas Department of Health Web site (www.healthyarkansas.com) has downloadable and printable posters that may be placed in the hospital or clinician’s office. Titled “Help Fight the Flu in Arkansas,” these three posters remind people about the importance of hand washing, covering their coughs, and staying home when they are sick.

If hospitals or clinicians’ offices have digital message boards in their waiting rooms or public places or the ability to embed video messages on their in-office screens, there is also a downloadable hand washing video available at this site.

The AHA also suggests that you consider offering surgical masks now to persons entering your hospital with symptoms of a respiratory illness (coughing, sneezing, etc.). Having signs posted outside your ED or admissions office, along with a box of surgical masks, may go a long way to protecting other patients and your hospital staff from illness.

And, above all, we encourage you to vaccinate your healthcare workers for seasonal flu.

You may find the following Web sites helpful when working with your medical staff:

http://www.cdc.gov/h1n1flu/guidance/
http://www.cdc.gov/h1n1flu/guidance_homecare_directions.htm
http://www.cdc.gov/h1n1flu/cdcresponse.htm
http://www.cdc.gov/flu/pandemic/healthprofessional.htm
http://www.healthyarkansas.com
It may be hard to believe, but October is right around the corner, and very soon the streets of downtown Little Rock will spill over with nearly 40,000 pink-clad participants in the 16th Annual Komen Arkansas Race for the Cure.

Finding a cure for breast cancer is important to all of us—so many of us are affected either directly or indirectly. When the Nurses for the Girls team was created by our team captain, Jaime Alverson—a labor and delivery nurse at Baptist Health—she shared her story about her mother, also a nurse, who died from breast cancer when she was a little over a year old. Soon after, we heard from other nurses sharing their personal stories of survival along with their stories of love and care towards patients undergoing treatment.

Now is the time to join the cause at nursesforthegirls.com. Our team is primarily comprised of nurses, but anyone can join. Invite your friends and family to race alongside. Share your story with us on our Facebook page. When you become a member of our team, you’ll also have the opportunity to support nurses through the ThinkAboutItNursing Scholarship Fund.

Nurses for the Girls would like to thank KTHV’s Stefanie Bryant, Jeff Matthews and Lisa Fischer from B98.5, and all of the Citadel Broadcast stations for supporting our efforts!
A little more than 10 years ago, back in February 1999, Jim Teeter, the former Arkansas Hospital Association president, penned a piece for his column that once filled this space warning of a possible flu pandemic. Then, it was the avian flu getting all the attention, especially since an avian flu pandemic scare two years earlier never materialized, and it had been 40 years since a pandemic of the Hong Kong flu claimed about 34,000 lives worldwide in 1968-69. The pervasive fear was that the law of averages was about to catch up with us.

The recurrence of avian flu in early 1999 made people even more sensitive to the idea of a pandemic. That year, the A/H9N2 virus – slightly different from the 1997 version by a couple of numerals – created quite a scare because of its presence in migratory birds rather than chickens, the carriers in 1997, which do well to fly a few feet in any direction. (Teeter pointed out that, had authorities not moved immediately to kill and properly dispose of millions of chickens in the Far East, the human outbreak could have been catastrophic.)

The birds’ capacity to fly long distances, combined with their ability to infect humans directly and the knock of influenza viruses to mutate like some sort of Terminator android to become more transmissible among people, was an ongoing concern for public health officials. The rest of us could barely get over the idea that many of the most severe flu cases were reported to have occurred in young adults. That was a characteristic similar to the 1918-19 Spanish flu outbreak, the gold standard of pandemics in recent world history, which was responsible for up to 500,000 deaths in the U.S. and more than 20 million around the globe.

Thankfully, a flu pandemic never arrived back in ’99, and it has stayed at bay. While the past decade held another minor flu outbreak in the Netherlands and the spread of severe acute respiratory syndrome (SARS) to 29 countries, killing nearly 10 percent of the people it infected, both stopped short of the pandemic level. Needless to say, all of us – Arkansans, Americans and mankind in general – have been blessed. But, let’s not take it for granted; that doesn’t mean that the pandemic threat is over or that we should let our guard down.

Now we’re facing the possibility of another pandemic threat from the H1N1 influenza virus, the dreaded Swine Flu. H1N1 has visited before, most recently back in 1976, when quick action to mass-immunize the population pretty much stopped it in its tracks. However, this time it could be different. There seems to be concerns that today’s H1N1 virus might turn out to be more like the 1918 epidemic, which started off mild then reemerged to kill millions. The advice found in the title of The Impressions’ 1965 song People Get Ready never rang so true.

The prospects for a pandemic in the coming months are so troubling that the Arkansas Department of Health is working overtime to ensure that state healthcare providers, especially hospitals, are ready for the spillover related to H1N1 flu, just in case. The Arkansas Hospital Association (AHA) is involved, too. On page 39 of this magazine, the AHA presents a reminder about items that hospitals should review with their medical staff members to make certain everyone is on the same page when it comes to widespread flu in their local community. If ever there was a time for hospitals to be geared-up to implement their flu preparedness plans at a moment’s notice, as well as take other precautionary steps, this is it.

Ten years ago, Dr. Sandra Snow, medical director of the ADH’s Division of Immunizations/Communicable Disease, warned the AHA Board that it’s not a matter of “if” such an outbreak of influenza will occur. The only uncertainty, she said, is when it will hit. Despite the fact that we’ve been able to dodge the bullet for a decade, her opinion hasn’t changed.

Flu pandemics happen. We knew that in 1999, and we know it today. At least 31 pandemics have been documented, dating back to the 16th century, three of them since 1900, but not one in the past 40 years. So, will the H1N1 scare morph into a full-blown pandemic in the coming months? We can only speculate, but it’s about time. When it comes to pandemics and the law of averages, it’s all about time.
Pre-Register for H1N1 Vaccine Supplies

The H1N1 virus (aka swine flu) has continued to cause illness, hospitalizations and deaths in the U.S. during the normally flu-free summer months, raising uncertainty about the upcoming flu season. To counter the possibility of a severe flu outbreak, the federal Centers for Disease Control and Prevention’s (CDC) Advisory Committee on Immunization Practices has taken an important step to prepare for a voluntary H1N1 vaccination program. As part of this effort, the federal government will provide states with H1N1 pandemic vaccine and supplies (i.e., needles, syringes, sharps containers, alcohol swabs) at no cost.

The Arkansas Department of Health (ADH) will be responsible for directing the shipment of the vaccine and supplies within the state. Dr. Sandy Snow, medical director, Immunization Section of the ADH, has notified state healthcare providers, including hospitals, clinics and pharmacists, about the opportunity to receive and administer the pandemic vaccine to people in their communities.

While all conditions of this federal program have not been finalized, interested providers are being asked to complete a pre-registration survey for their vaccine supplies and to receive information about the program at no cost and with no obligation. Hospitals completing the survey are able to provide the Department with an estimate of the total number of staff to be vaccinated, as well as the total number of other persons that they intend to vaccinate. Vaccine is expected to begin shipping by mid-October. However, at this time, the ADH cannot guarantee that all preregistered providers will receive vaccine directly shipped to them or the timing or size of shipments.

The Arkansas Hospital Association provided all member organizations with details for preregistering in a September 2 e-mail to hospital CEOs from Beth Ingram. For other assistance, contact the Immunization Network for Children (INC) Help Desk at (800) 574-4040.

Instructions for Billing H1N1 Vaccine

A new Special Edition MLN Matters article regarding billing for the administration of the influenza A (H1N1) vaccine is now available on the CMS Web site. This article explains Medicare coverage and reimbursement rules for the H1N1 vaccine and also addresses seasonal flu coverage and reimbursement.

Medicare will pay for seasonal flu vaccinations even if the vaccinations are rendered earlier in the year than normal. CMS acknowledges that such preparations are critical for the upcoming flu season, especially in planning for the influenza A (H1N1) vaccine.

Though Medicare typically pays for one vaccination per year, if more than one vaccination per year is medically necessary (i.e., the number of doses of a vaccine and/or type of influenza vaccine), then Medicare will pay for those additional vaccinations. Medicare claims processing contractors have been notified to expect and prepare for earlier-than-usual seasonal flu claims, and there should not be a problem in getting those claims paid. Furthermore, in the event that it is necessary for Medicare beneficiaries to receive both a seasonal flu vaccination and an influenza A (H1N1) vaccination, then Medicare will pay for both.

Please be advised that if either vaccine is provided free of charge to the healthcare provider, then Medicare will only pay for the vaccine’s administration, not for the vaccine itself.

All providers administering the flu vaccine should review the article and be sure that their billing staffs are aware of this information. For more information, please read the article located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0920.pdf.
EMTALA Allows Flexibility During Disasters

The Centers for Medicare & Medicaid Services (CMS) issued an August 14 memorandum to state survey agencies regarding Emergency Medical Treatment and Labor Act (EMTALA) requirements and the flexibility allowed under the law during disasters. The memo was sent in anticipation of a possible significant increase in demand for emergency services due to an expected H1N1 influenza resurgence this fall. CMS stated in the memo that federal agencies, state health departments and hospitals have expressed concerns about compliance with EMTALA requirements in case there is an outbreak of the virus.

The correspondence seeks to dispel a common perception that EMTALA imposes heavy restrictions on hospitals’ ability to provide adequate care when emergency departments (ED) experience extraordinary surges in demand. Along with the memo, CMS included a fact sheet clarifying permissible options for EMTALA compliance should the increased demand occur.

Among other things, the fact sheet notes that an EMTALA-mandated medical screening examination (MSE) does not need to be an extensive work-up in every case, and that it may even be conducted outside the ED. For example, hospitals may set up alternative screening sites on campus or at off-campus, hospital-controlled sites, and communities may set up screening clinics at sites not under the control of a hospital. Further, the law provides for waivers of certain EMTALA requirements in a declared public health emergency.

Surveyors and managers responsible for EMTALA enforcement are instructed to be aware of the flexibilities hospitals are currently afforded under EMTALA and to assess incoming EMTALA complaints accordingly in determining overall compliance and whether an on-site investigation is required. CMS’ memo and fact sheet can be found by clicking on the following link: http://arkhospitals.org/disasterpdf/SCLetter09_52.pdf.

JCR Launches 2009 Flu Vaccination Challenge

On August 18, Joint Commission Resources (JCR) officially launched the 2009-2010 Flu Vaccination Challenge.

JCR created the Flu Vaccination Challenge in 2008-2009 to increase healthcare worker vaccination rates and help decrease the risk of passing the flu onto patients. During the inaugural year of the Flu Vaccination Challenge, JCR encouraged hospitals across the country to achieve flu vaccination rates higher than the national average of 42 percent. More than 1,700 hospitals all across the country participated in “the Challenge,” and an impressive 1.1 million healthcare workers were vaccinated.

This year, JCR is “raising the bar” and introducing a tiered approach to setting this year’s seasonal flu vaccination goals. Healthcare facilities will be challenged to reach a 65, 75 or 90 percent vaccination rate. The tiered approach encourages healthcare facilities to strive for a better vaccination rate than achieved the previous year. Those that do will be recognized by JCR for their dedication to keeping their employees healthy and helping to protect their patients. JCR is also broadening “the Challenge” to include healthcare workers in ambulatory and long-term care facilities, emphasizing the importance of flu vaccination and patient safety beyond the hospital setting.

Any questions related to the Flu Vaccination Challenge may be directed to Gina LaMantia, program manager, Department of Education, 630.792.5427. For additional information, resources, and registration for the 2009-2010 Flu Vaccination Challenge, please visit the Web site at www.fluvaccinationchallenge.com.

Medicare FFS Policies Relating To Flu Pandemic

CMS has issued information on Medicare fee-for-service policies and procedures in an H1N1 flu pandemic or other public health emergency or disaster. The 22-page document addresses issues related to H1N1 vaccination, flexibilities available in an emergency or disaster, waivers of certain Medicare requirements in a declared emergency or disaster, and payment polices and billing procedures for various types of healthcare services and providers. For more, see http://www.cms.hhs.gov/Emergency/Downloads/Medicare_FFS_Downloads/Qs_As_082609.pdf.
**Stimulus Plan Releases $1.2 Billion to Support EHR Adoption**

Vice President Joe Biden on August 20 announced $1.2 billion in American Recovery and Reinvestment Act grants to help hospitals and other healthcare providers become meaningful users of electronic health records.

The grants include $598 million to establish an estimated 70 regional centers to help primary care providers achieve meaningful use of certified EHRs, and $564 million to help states exchange electronic health information through the meaningful use of EHRs.

“This is the first significant flow of ARRA funds for health IT, and importantly, begins the process of providing the kind of support many healthcare providers will need as they implement information technology,” said Rod Piechowski, American Hospital Association senior associate director for policy.

The Centers for Medicare & Medicaid Services is expected to draft a proposed rule defining “meaningful use,” which will determine which hospitals and physicians are eligible for more than $17 billion in health IT funding under the ARRA’s HITECH provisions.

**Breach Notification Rule for EHI**

The Federal Trade Commission has released an interim final rule implementing the Information Technology for Economic and Clinical Health Act’s breach notification requirements. The Act obligates hospitals and other HIPAA-covered entities and their business associates to notify individuals when the privacy of their “unsecured” personal health information is breached.

The notice obligations are effective for breaches occurring on or after September 24. However, because covered entities may require time to implement compliance programs, HHS will use its “enforcement discretion to not impose sanctions for failure to provide [notices] for breaches that are discovered before 180 calendar days” from the rule’s August 24 publication in the Federal Register. To access more information, see the HHS press release at http://www.hhs.gov/news/press/2009pres/08/20090819f.html.

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**X-RAY VISION. HEALING POWERS. THE STRENGTH OF 40 THOUSAND.**

Every day, they perform some of life’s greatest feats — mending broken bones, healing hearts, touching our lives for the better. They’re here for us; coming to our aid when tragedy strikes, caring for us when we become sick, and helping us maintain our health. They’re the 40,000 men and women who work in our hospitals, who dedicate their lives to saving ours. They’re our friends, our neighbors and, for many of us, they’re our heroes.

**AND YOU DON’T HAVE TO WAIT UNTIL SATURDAY MORNING TO SEE THEM.**

^Arkansas Hospital Association 1929
Committee Adopts “Meaningful Use” Definition

The Health Information Technology Policy Committee on July 16 adopted a revised definition of “meaningful use” of electronic health records (EHR), which CMS will use to draft a proposed rule defining which hospitals and physicians are eligible for health information technology (HIT) funding under the American Recovery and Reinvestment Act.

Based on comments received on a draft definition issued by the Office of the National Coordinator for Health Information Technology, the revised definition matrix would give hospitals and physicians greater flexibility in meeting the timeline for adopting certain elements of EHR for receiving a full payment update.

A committee work group also unveiled its initial recommendations related to EHR certification. The American Hospital Association is reviewing the definition and the EHR recommendations and will provide more details to members in an upcoming communication.
AHA, State and Federal Officials Discuss NDMS Issues

On September 1, 2008 Hurricane Gustav made landfall in southern Louisiana. In preparation for that major weather event, the National Disaster Medical System (NDMS) activated nearly a dozen hospitals in the Little Rock metropolitan area and readied them to accept around 200 patients who were being evacuated to Arkansas from hospitals in the hurricane’s path.

A few days later, Hurricane Ike followed in Gustav’s wake, causing prolonged stays in Arkansas for most of those Louisiana patients.

Almost a full year later, many of the NDMS claims related to care provided to those evacuated patients remain unpaid.

In early August, members of the Arkansas Hospital Association executive staff, along with executives and managers from several central Arkansas hospitals, met with representatives from the Arkansas Department of Health, federal officials from the Dallas Regional Offices of the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services, the Veterans Administration and HHS’ Office of Preparedness and Response Program to discuss those and other issues stemming from NDMS’ patient evacuation in advance of Hurricane Gustav.

Discussions centered on the status of the current unpaid claims and changes needed to cover reimbursement for care rendered during similar future disasters.

But they also included post-disaster repatriation of patients, communications between and among agencies and providers, and the NDMS Memorandum of Agreement (MOA).

During the meeting, HHS acknowledged that reimbursement problems occurred following Gustav and Ike and said that for the upcoming hurricane season, steps are in place to reduce the bureaucracy and time it takes for payments to flow to hospitals.

Work also is underway by HHS’ Assistant Secretary for Preparedness and Response to enact changes to make the NDMS more responsive to provider problems and to have a new MOA prior to the June 1, 2010 hurricane season.

Arkansas Hospitals Participate In Statewide Drill

On Wednesday, June 24, Arkansas hospitals participated in a four-hour statewide exercise designed to test the state’s ability to respond to a large-scale public health crisis.

The drill involved emergency preparedness planners from hospitals, as well as state and local agencies rehearsing what they would do in the hours and days following an actual public health emergency.

The exercise allowed hospital emergency responders to evaluate their capacity to interact with other emergency responder groups using proper personnel, communications systems and operational abilities.

In addition to working with state and local agencies, the exercise offered opportunities for hospitals to interact with federal agencies, such as the Centers for Disease Control (CDC) and the Strategic National Stockpile (SNS).

The SNS is prepared with stockpiled medicine and medical supplies ready to ship to hospitals when local supplies run out. Once federal and local authorities agree that the SNS is needed, shipments will be delivered to any state in the U.S. within 12 hours. The Health Department will receive the shipment and distribute it to hospitals as needed.
different patients, different needs.

As a health care provider, you understand that no two patients are alike. That’s why the Centers for Disease Control and Prevention recommends specific flu vaccines based on a patient’s age and health status.

Most seniors and others with long-term health conditions need an annual flu vaccination. By ensuring that your patients get the right type of vaccine, you can help all Arkansans stay healthy and well this winter. And remember, it’s vital that health care workers are also vaccinated.

We don’t provide health care. We help make it better.

As a national leader in health care quality improvement, AFMC is helping to ensure every patient gets the right care at the right time, every time.

Approved influenza vaccines for different age groups:
United States, 2009-10 season [MMWR 2009;58]

<table>
<thead>
<tr>
<th>MANUFACTURER</th>
<th>TRADE NAME/ VACCINE</th>
<th>PRESENTATION</th>
<th>AGE GROUP</th>
<th>NUMBER OF DOSES</th>
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<tbody>
<tr>
<td>Sanofi Pasteur, Inc.</td>
<td>Fluzone® TIV</td>
<td>0.25 mL prefilled syringe</td>
<td>6-35 months</td>
<td>1 or 2*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.5 mL prefilled syringe</td>
<td>≥36 months</td>
<td>1 or 2*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.5 mL vial</td>
<td>≥36 months</td>
<td>1 or 2*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5.0 mL multidose vial</td>
<td>≥6 months</td>
<td>1 or 2*</td>
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<tr>
<td>Novartis Vaccine</td>
<td>Fluvirin™ TIV</td>
<td>5.0 mL multidose vial</td>
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<td>GlaxoSmithKline</td>
<td>Fluarix™ TIV</td>
<td>0.5 mL prefilled syringe</td>
<td>≥18 years</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>FluLaval™ TIV</td>
<td>5.0 mL multidose vial</td>
<td>≥18 years</td>
<td>1</td>
</tr>
<tr>
<td>CSL Biotherapies</td>
<td>Afluria</td>
<td>0.5 mL prefilled syringe</td>
<td>≥18 years</td>
<td>1</td>
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<tr>
<td></td>
<td></td>
<td>5.0 mL multidose vial</td>
<td>≥18 years</td>
<td>1</td>
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<tr>
<td>MedImmune</td>
<td>FluMist™ LAIV</td>
<td>0.2 mL sprayer</td>
<td>2-49 years</td>
<td>1 or 2**</td>
</tr>
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</table>

TIV: Trivalent Inactivated Vaccine • LAIV: Live Attenuated Influenza Vaccine

*Two doses administered at least 1 month apart are recommended for children aged 6 months–8 years who are receiving TIV for the first time, and those who only received 1 dose in their first year of vaccination should receive 2 doses in the following year.

**Two doses administered at least 4 weeks apart are recommended for children aged 2–8 years who are receiving LAIV for the first time, and those who only received 1 dose in their first year of vaccination should receive 2 doses in the following year.

SOURCE: 2009 Recommendations of the Advisory Committee on Immunization Practices, Centers for Disease Control and Prevention
Arkansas Hospital Association
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Little Rock, AR  72205

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